**MEDICAL HISTORY**

1. Are you in good health? Yes / No
2. Have you had any recent dental work performed? Yes / No

If so, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you had any serious trouble associated with previous dental treatment? Yes / No

If so, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are there any concerns regarding your visit and treatment at our office? Yes / No

If so, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Family physician’s information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Please indicate if you have had / currently have any of the following:

\_\_\_ AIDS/HIV infection \_\_\_ Irregular heartbeat \_\_\_ Bleeding Disorder

\_\_\_ Asthma \_\_\_ Epilepsy \_\_\_ Stomach ulcers/Colitis

\_\_\_ Stroke \_\_\_ Diabetes \_\_\_ Organ transplant

\_\_\_ Cancer/Chemo/Radiation \_\_\_ Immunosuppression \_\_\_ None of the Above

\_\_\_ Heart Disease \_\_\_ Hepatitis

\_\_\_ High Blood Pressure \_\_\_ Kidney Disease

1. Are you now under the care of a physician? Yes / No

If so, what is/are the condition(s) being treated? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please list all prescribed medications, over the counter medications/vitamins you are taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Have you ever had an orthopedic joint replacement?

\_\_\_ Yes, within last 2 years \_\_\_ Yes, more than 2years ago \_\_\_ No

1. Have you ever / are you currently taking bisphosphonates for osteoporosis? Yes / No
2. Do you have any disease, condition or problem not listed above? Yes / No

If so, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you take antibiotics / premedication before each dental appointment? Yes / No
2. Are you / could you currently be pregnant? Yes / No If so, due date: \_\_\_\_\_\_\_\_\_\_\_\_\_
3. Do you use tobacco - smoking, snuff, chew? Yes / No
4. Are / have you been alcohol and/or drug dependent? Yes / No
5. Are you allergic to latex? Yes / No
6. Are you allergic to / have you had a reaction to penicillin/other antibiotics? Yes / No
7. Are you allergic to / have you had a reaction to narcotics? Yes / No

If so, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Are you allergic to / have you had a reaction to any of the following:

\_\_\_ Local Anesthetic \_\_\_ Household Bleach

\_\_\_ Ibuprofen (Advil) \_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ Acetaminophen (Tylenol)

To the best of my knowledge, the above information is correct and accurate. I, the undersigned, consent to the performing of any procedures necessary to evaluate, diagnose and treat myself or my child’s condition. I authorize and request the administration of such drugs and/or anesthetics as may be deemed advisable by the dentist.

Signature (patient, parent or guardian) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT – Please add an emergency contact name & phone number

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ Ph: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_