Medical History

		If Yes, Please List:
Are you under a physician's care now?	___Yes ___No	_____
Have you ever been hospitalized or had a major operation?	___Yes ___No	_____
Are you taking any medication, pills or drugs?	___Yes ___ No	_____
Do you use controlled substances?	___Yes ___No	_____
Do you use tobacco?	___Yes ___No	_____

Women Are you: Pregnant - Trying to get pregnant ___ / Nursing ___ / Taking Contraceptives___

Are you Allergic to any of the following:
Aspirin ___ Penicillin ___ Codeine___ Acrylic ___ Metal ___ Latex ___ Local Anesthetics___
Amoxicillin ___ Sulfa ___ Other (Please List):_____

Do you have or ever had any of the following:

___AIDS/HIV Positive	___Emphysema	___Hives or Rash	___Spina Bifida
___Alzheimer's Disease	___Epilepsy/Seizures	___Hypoglycemia	___Stroke
___Anemia	___Excessive bleeding	___Kidney Disease	___Swelling
___Arthritis/Gout	___Fainting/Dizziness	___ Leukemia	___Thyroid Disease
___Artificial Heart Valve*	___Frequent Headaches	___ Liver Disease	___Tonsillitis
___Artificial Joints*	___Herpes Simplex	___ Low Blood Pressure	___Tuberculosis
___Asthma	___Glaucoma	___ Lung Disease	___Tumors
___Blood Disease	___Hay Fever/Allergies	___Mitral Valve Prolapse*	___Ulcers
___Blood Transfusion	___Heart Attack/Failure	___ Renal Dialysis	
___Cancer	___Heart Disease	___ Rheumatic Fever*	
___Chemotherapy	___Heart Murmur*	___ Scarlet Fever	
___Cold Sores/Fever Blister	___Hemophilia	___ Shingles	
___Congenital Heart Disorder	___Hepatitis A, B, or C	___ Sickle Cell Disease	
___Diabetes	___High Blood Pressure	___ Sinus Problems	

Have you ever had any serious illness not listed? _____ Yes _____ No
Comments:

Patient Dental History:

Do your gums bleed while brushing or flossing?	__Yes __No	Do you clench or grind your teeth?	__Yes __No
Are your teeth sensitive to hot/cold liquid or food?	__Yes __No	Prolonged bleeding after extractions?	__Yes __No
Do you feel pain in any of your teeth?	__Yes __No	Have you had any orthodontic treatment?	__Yes __No
Have you had any head, neck, or jaw injuries?	__Yes __No	Do you wear dentures or partials?	__Yes __No
Do you like your smile?	__Yes __No	Do you have frequent headaches?	__ Yes __No
Would you like your teeth to look whiter?	__Yes __No		

How long has it been since your last dental visit? _____

Do you have any of the following in your jaw:
-clicking __Yes __No
-pain (joint, ear, side of face) __Yes __No
-difficulty chewing __Yes__No

Authorization and Consent:
I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing the incorrect information can be dangerous to my health. I give my consent to be seen by the doctor and if I elect treatment, I consent for the work to be done and understand that during the course of the procedure(s) unforeseen conditions may occur which necessitate procedures other than contemplated. I am aware there may be additional charges.
If a collection problem arises, I understand that I am responsible for all collection fees including attorney fees, court costs, and late charges.

HIPAA:
I have received and acknowledged the Notice of Privacy Practice and consent for use and disclosure of health information. I give this practice consent to use or disclose my health information to carry out treatment, obtain insurance payments and health care operations.

Signature of patient or parent/legal guardian: _____ **Date:** _____