The personal information and medical history requested below is to enable me to give you the most consideration of your time and feelings, and to aid in evaluating your dental health thoroughly and completely. It is important for you to give complete answers so that I may give you personal attention. This will become part of your dental record and will be held in strict confidence. ***THANK YOU***

PERSONAL INFORMATION Date: ____________________

Patient Name: ____________________ Birthdate: ____/____/____

HEALTH HISTORY (Please circle Yes or No or answer question)

Do you consider your medical health good?............. Yes No
Are you under the care of a physician?..................... Yes No
For what reason? ____________________

Name of your physician ____________________
Have you had major surgery?.................................... Yes No
When? ____________________
For What? ____________________
Have you been in the hospital recently? .... Yes No
When? ____________________
For What? ____________________

Do you have any allergies to medications? .... Yes No
To what medications? ____________________

Do your gums bleed?... Yes No
Do you have difficulty chewing your food?................ Yes No
Have you ever worn braces on your teeth?............... Yes No
Are you having any discomfort or pain from your mouth or face now?... Yes No
Lately?.. Yes No
Are you aware of any dental needs now?................. Yes No
Are you pregnant now?... Yes No
What month? ____________________
Do you use tobacco?.. Yes No
Are you taking any medications or natural dietary supplements?... Yes No

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

Anemia .... Yes No
Arthritis, Gout.. Yes No
Artificial heart valve/congenital heart condition......... Yes No
Asthma.. Yes No
Bleeding problems/on blood thinners....................... Yes No
Cancer, Leukemia, Tumor, Cyst............................... Yes No
Diabetes.. Yes No
Epilepsy/Seizures... Yes No
Glaucoma... Yes No
Heart disease, Heart attack.................................... Yes No
Hepatitis, Jaundice.. Yes No
High or Low Blood Pressure.................................... Yes No
Joint replacement/Year? ________.......................... Yes No
Kidney or bladder trouble...................................... Yes No
Latex allergy... Yes No
Lung trouble, Emphysema, T.B, COPD..................... Yes No
Osteoporosis.. Yes No
-Are you or have you taken Boniva, Fosamax, or Actonel? Yes No
-Intravenous bisphosphonate therapy? Yes No
Psychiatric treatment.. Yes No
Radiation treatments to head/neck area.................... Yes No
Stroke... Yes No
Tested positive for HIV.. Yes No
Ulcers... Yes No

Please list: ____________________

What have you liked the most about any dental office you have been to before? ____________________

What have you liked the least? ____________________
Are you happy with your smile?.. Yes No
Are you interested in avoiding bad breath?.. Yes No
Have you ever had any illness or complications associated with any previous dental treatment?............ Yes No
Have you ever had a frightening experience with dentistry?........................ Yes No
Have you ever been asked to pre-medicate prior to any dental treatment?...... Yes No

Thank you for your cooperation. If there is any other information of any kind which you feel would be of value to us in any way, please add such information here: ____________________

PLEASE SIGN BELOW

Signature Date

Signature Date

Signature Date

I ACKNOWLEDGE I HAVE RECEIVED A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES.

Signature Date