

Medical Information

- | | YES | NO |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 1. Are you having pain or discomfort at this time? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you been a patient in a hospital during the last two years? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you now taking any medication or drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please list: _____ | | |
| 4. Have you been taking any medication or drugs during the last two years including the appetite suppressant fen-phen (fenfluramine & phentermine) or dexfenfluramine or fenfluramine? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you been under the care of a medical doctor during the last two years or since taking any of the appetite suppressants named above? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, Physician's Name _____ Phone# (____) _____
Address _____ | | |
| 6. Are you sensitive to any medication or anesthetics? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please list _____ | | |

7. Indicate which of the following you have had or have at the present. Check "Y" for yes or "N" for no to each item.

- | Y N | Y N | Y N |
|----------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|
| <input type="checkbox"/> <input type="checkbox"/> Heart failure | <input type="checkbox"/> <input type="checkbox"/> Artificial Joints (hip, knee, etc.) | <input type="checkbox"/> <input type="checkbox"/> Hepatitis A (infectious) |
| <input type="checkbox"/> <input type="checkbox"/> Heart Disease or Attack | <input type="checkbox"/> <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> <input type="checkbox"/> Hepatitis B (serum) |
| <input type="checkbox"/> <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> <input type="checkbox"/> Ulcers | <input type="checkbox"/> <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> A.I.D.S. |
| <input type="checkbox"/> <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> <input type="checkbox"/> H.I.V. Positive |
| <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Glaucoma | <input type="checkbox"/> <input type="checkbox"/> Cold Sores / Fever Blisters |
| <input type="checkbox"/> <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> <input type="checkbox"/> Cancer | <input type="checkbox"/> <input type="checkbox"/> Blood Transfusion |
| <input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> <input type="checkbox"/> Emphysema | <input type="checkbox"/> <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> <input type="checkbox"/> Anemia |
| <input type="checkbox"/> <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> <input type="checkbox"/> Asthma | <input type="checkbox"/> <input type="checkbox"/> Bruise Easily |
| <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> <input type="checkbox"/> Hay Fever | <input type="checkbox"/> <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> <input type="checkbox"/> Arthritis | <input type="checkbox"/> <input type="checkbox"/> Allergies or Hives | <input type="checkbox"/> <input type="checkbox"/> Yellow Jaundice |
| <input type="checkbox"/> <input type="checkbox"/> Rheumatism | <input type="checkbox"/> <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> <input type="checkbox"/> Epilepsy or Seizures |
| <input type="checkbox"/> <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> <input type="checkbox"/> Fainting or Dizzy Spells |
| <input type="checkbox"/> <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> <input type="checkbox"/> Stroke | <input type="checkbox"/> <input type="checkbox"/> Developmentally Disabled | <input type="checkbox"/> <input type="checkbox"/> Tumors |
| <input type="checkbox"/> <input type="checkbox"/> Allergy to Latex | <input type="checkbox"/> <input type="checkbox"/> Allergy to metal (jewelry, etc.) | |

- | | YES | NO |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 8. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath or because you are very tired? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do your ankles swell during the day? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you use more than two pills to sleep? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Have you lost or gained more than ten pounds in the last year? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you ever wake up from sleep and feel short of breath? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Are you on a special diet? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Do you have or have you had any disease(s), condition(s), or problem(s) not listed? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please list _____ | | |

FOR WOMEN ONLY

Are you pregnant? Yes (Month _____) Are you nursing? Y N Are you taking birth control pills? Y N

The above information is accurate and complete to the best of my knowledge, and is only for use in my treatment, billing, and processing of insurance or benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I also acknowledge full responsibility for the payment of such services and agree to pay for them in full, at the time of service, unless other arrangements are made with the financial department.

Emergency Contact _____ Phone (____) _____

Patient Signature _____ Date _____

FOR OFFICE USE ONLY

Reviewed by _____ Date _____

Don't wait until it hurts. Let us help.

Dental Information

1. Are your teeth sensitive to heat or cold? Yes No Pressure? Yes No Sweets? Yes No
2. Do you grind or clench your teeth? _____
3. Do you have any fear of dental work? _____
4. Date of last dental visit _____ What was done at the time? _____
5. Former Dentist Name _____ City _____
6. How would you describe your current dental problem? _____
7. How do you feel about the appearance of your teeth? _____

American Dental Association - Warning Signs of Periodontitis Disease

Periodontal disease is painless. It affects 75% of the population, and victims are often unaware.

8. Do your gums bleed when you brush your teeth? Yes No
9. Are your gums red, swollen, or tender? Yes No
10. Have your gums pulled away (receded) from your teeth? Yes No
11. Is there pus between your teeth and gums when gums are pressed? Yes No
12. Are your permanent teeth loose or separating? Yes No
13. Have you noticed any changes in the way your teeth fit when biting? Yes No
14. Have you noticed any change in fit of partial dentures? Yes No
15. Do you have persistent bad breath? Yes No

16. Do you snore? Yes No
17. Does anyone in your family snore? Yes No

18. What changes would you like to see in the appearance of your smile?
