Health History

Have you had a serious illness, surgery or been hospitalized in the past 5 years? _____
If so, what was the problem? _____
Date of last medical ck-up_____ Are you under a physician's care now? _____Reason: _____
What prescription medications do you take? (***Include birth control as antibiotics interfere.***)

Do you currently or have you ever had any of the following:

Do you get mouth sores, cold sores, canker sores or fever blisters? Yes or No

	Yes	No
Rheumatic fever	___	___
Rheumatic heart disease	___	___
Jaundice	___	___
Heart Disease	___	___
Heart attack	___	___
High blood pressure	___	___
Stroke	___	___
Chest Pain	___	___
Shortness of breath	___	___
Swollen ankles	___	___
Blood disorders	___	___
Anemia	___	___
Blood test w/unusual result	___	___
Abnormal bleeding	___	___
Prolonged healing	___	___
Bruise easily	___	___
Asthma, hay fever	___	___
Spina Bifida (Surgeries)	___	___
Low blood pressure	___	___
Fainting spells	___	___
Seizures	___	___
Heart murmur	___	___
Mitral-Valve Prolapse	___	___

	Yes	No
Are you pregnant?	___	___
Liver disease	___	___
Hepatitis	___	___
Kidney disease	___	___
Arthritis	___	___
Tuberculosis	___	___
Lung ailments	___	___
Persistent Cough	___	___
Cough up Blood	___	___
Diabetes	___	___
Radiation for tumor	___	___
Allergic to Penicillin	___	___
Allergic to Aspirin	___	___
Allergic to Latex	___	___
Artificial heart valves	___	___
Artificial joints	___	___
Cancer	___	___
Jaw pain	___	___
Pacemaker	___	___
Autoimmune disorder	___	___
HIV Positive	___	___
Do you have any disease/ condition not listed here?	___	___

Please list your allergies to medications: _____
Please list your allergies to foods: _____
Have you had to take an antibiotic before having dental work in the past? If yes, what type?

Do you have any allergies to jewelry or metals?	**Yes**	**No**
Do you break out on neck, ears, or fingers?	**Yes**	**No**
Do you dislike the color of your teeth?	***Yes***	***No***
Do you have spaces between your teeth?	***Yes***	***No***
Do you have chips or uneven edges on your teeth?	***Yes***	***No***
Do you feel your teeth are too long or too short?	***Yes***	***No***
Do your gums show too much when you smile?	***Yes***	***No***
Are your teeth crooked or crowded?	***Yes***	***No***
Are you self-conscious about your teeth or smile?	***Yes***	***No***
Would you like to improve your existing smile?	***Yes***	***No***

Why did you leave your last dentist? _____
Rate the dental work you currently have in your mouth. ***Poor 1 2 3 4 5 6 7 8 9 10 great***
What rate of dental work do you WANT to have in your mouth? ***1 2 3 4 5 6 7 8 9 10***
If you could change anything about your smile, what would it be? _____

*** I authorize the release of a full report of examination findings, diagnosis, treatment programs, etc., to any referring or treating dentist or physician.**

*** I give permission for my dentist and his clinical team to make any necessary diagnostic photos or study models to enable complete diagnosis and treatment.**

*** I additionally authorize the release of medical information to insurance companies for legal documentation.**

*** I understand that my insurance is an agreement between my insurance company and me, and that I am responsible for my balance regardless of my insurance.**

*** I understand that I may be charged a 1.5% per month or 18% per year finance charge if my balance goes beyond 90 days.**

Signature: _____ **Date:** _____
*** I have read, agreed to, and understand the statements listed above.**
(If patient is a minor then Parent or Guardian must sign)