PATIENT MEDICAL/DENTAL HISTORY

Name_____Date_____

What is the reason for today's visit?_____
Do you have any questions or concerns we can help you with today?_____
_____
If there is a simple, inexpensive way to whiten your teeth, would you be interested?_____
If you could wave a magic wand and change one thing about your smile, what would it be?_____
Are you interested in avoiding bad breath?_____
Why did you leave your last dentist?_____
What did you like most about any dentist you've ever seen?_____
What did you like least about any dentist you've ever seen?_____

MEDICAL HISTORY AND INFORMATION

Doyou have or have you ever had?

Y	N	
❒	❒	Arthritis
❒	❒	Asthma
❒	❒	Cancer
❒	❒	Diabetes
❒	❒	Epilepsy
❒	❒	Glaucoma
❒	❒	Heart Murmur
❒	❒	Heart Problem_____
❒	❒	Hepatitis
❒	❒	High Blood Pressure
❒	❒	HIV Positive/AIDS
❒	❒	Jaundice
❒	❒	Joint Replacement
❒	❒	Kidney Problems
❒	❒	Low Blood Pressure
❒	❒	Rheumatic Fever
❒	❒	Sexually Transmitted Diseases
❒	❒	Stroke
❒	❒	Tuberculosis
❒	❒	Other_____

Are you allergic to?
❒ Aspirin ❒ Codeine
❒ Barbiturate ❒ Penicillin
❒ Other_____

Are you currently taking any prescription medications? ❒Yes ❒No
If yes, please list_____
_____

Are you currently under the care of a doctor? ❒Yes ❒No
Please explain_____
_____

Female Patients: Are you pregnant?
❒Yes ❒No
If yes, due date_____

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition. Payment for all treatment and services rendered are my responsibility.

_____ _____
Patient or Guardian's Signature Date