11. Have you ever had any organ implants or medical implants? ..... Yes ❑ ❑No
12. Have you ever fainted? ..... ❑ ❑
13. Do your ankles swell? ..... ❑ ❑
14. Do you experience shortness of breath or chest pain when taking a walk or climbing stairs? ..... ❑ ❑
15. Do you have frequent headaches? ..... ❑ ❑
16. Do you have A.I.D.S. or have you ever tested positive for H.I.V.? ..... ❑ ❑
17. Do you have any of the following? Please check any that apply ..... ❑ ❑

❑ Heart Murmur or Mitral Valve Prolapse	❑ Malignant Hyperthermia	❑ Liver Disease	❑ Herpes
❑ Stomach / Intestinal Problems / Ulcers	❑ Drug / Alcohol Dependency	❑ Heart Attack	❑ Sinus Trouble
❑ Joint Replacement (hip, knee, etc.)	❑ Venereal Disease	❑ Cold Sores	❑ Stroke
❑ Mental or Nervous Disorder	❑ Lung Disease (i.e. Asthma)	❑ Jaundice	❑ Kidney Problems
❑ High/low Blood Pressure	❑ Thyroid Disease	❑ Diabetes	❑ Emphysema
❑ Hyper (hypo) Glycemia	❑ Arthritis or Rheumatism	❑ Tuberculosis	❑ Glaucoma
❑ Epilepsy or Seizures	❑ Scarlet or Rheumatic Fever	❑ Hepatitis A,B,C	
❑ Cortisone/Steroid Therapy	❑ Cancer / Chemotherapy	❑ Other: _____	

18. Have you had any injury, surgery or x-ray therapy to your face or jaws? ..... ❑ ❑
19. Do you have any disease, condition, or problem that you think the doctor should know about? ..... ❑ ❑
20. WOMEN ONLY - Are you pregnant or suspect you might be? If so, what month are you in? _____ ❑ ❑
Are you taking birth control pills? ..... ❑ ❑
Are you nursing? ..... ❑ ❑

DENTAL HISTORY

Yes No

1. Reason for today's visit: ❑ Exam ❑ Cleaning ❑ Emergency ❑ Other _____
Are you presently having dental pain? ..... ❑ ❑
Is there a dental problem you would like to take care of as soon as possible? ..... ❑ ❑
Please specify: _____
2. How frequently do you see your dentist? ❑ 6 months ❑ Yearly ❑ Other _____
Former dentist: _____ Last dental visit: _____
Last cleaning: _____ Full mouth series of x-rays: _____
3. How often do you brush your teeth? _____ Floss? _____
4. Do your gums bleed easily? ..... ❑ ❑
5. Are your teeth sensitive to: ❑ Hot ❑ Cold ❑ Biting ❑ Sweets? ..... ❑ ❑
6. Do you feel you have bad breath at times? ..... ❑ ❑
7. Have you ever had jaw joint surgery? ..... ❑ ❑
8. Do you have pain in your jaw joints or suffer from migraine headaches? ..... ❑ ❑
9. Does any part of your mouth hurt when clenched? ..... ❑ ❑
10. Does your jaw crack or pop when opened widely? ..... ❑ ❑
11. Have you had: ❑ Braces ❑ Oral surgery ❑ Gum treatment ❑ Root canal ..... ❑ ❑
12. Do you grind or clench your teeth during the day or night? ..... ❑ ❑
13. Do you smoke? Number per day: _____ . ..... ❑ ❑
14. Do you or does any family member have a problem with snoring? ..... ❑ ❑
15. Have you ever experienced any growths or sore spots in your mouth? If so, where? _____ ❑ ❑
16. Previous problems with dental treatment? Specify: _____ ❑ ❑
17. Are you satisfied with the appearance of your teeth? ..... ❑ ❑
Please specify: _____
18. Other Dental Concerns: _____

Office policy: Your appointment time will be reserved especially for you. If you are unable to keep the appointment we will require 48 hours notice, otherwise it may be necessary to charge for the time lost.

Patient Release: I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical-dental history. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I also understand that consultation with my medical doctor may be required, and I consent to my physician being contacted as necessary. I understand that responsibility for payment for the dental services provided for myself and my dependants is mine, and I will assume responsibility for fees associated with these services.

	Date:	
	/ /	
(Signature) ❑ PATIENT ❑ PARENT ❑ GUARDIAN	MM DD YY	REVIEWING DENTIST