

Medical History

1. Name of your Physician _____
Date of last physical exam _____ Results _____
2. Do you have a heart or circulatory problem of any kind? Yes No
3. Have you had rheumatic fever? Yes No
4. Do you have a heart murmur? Yes No
5. Are you taking any medication or pills?. Yes No
Please Specify _____
Any other medication within the last year?. Yes No
Please Specify _____
6. Have you ever experienced an unusual reaction to any of the following: (Please Circle)
Aspirin Penicillin Tylenol Codeine Local Anesthetics Ibuprofen Others
7. Do you have any allergies? Yes No
Please Specify _____
8. Do you have a bleeding problem? Yes No
9. Have you ever had any injury, surgery or radiation therapy to your head, face or jaws?. Yes No
10. Have you ever had any major surgery?. Yes No
Please Specify _____
11. Do you smoke or use smokeless (chewing) tobacco? Yes No
Have you ever smoked or used smokeless (chewing) tobacco? Yes No
12. Are you Pregnant? (women) Yes No
13. Do you or have you ever had? (Please Circle)

| | | |
|------------------------|---------------------|-------------------------|
| AIDS/ARC/HIV+ | Diabetes | Mental/Nervous Disorder |
| Anemia | Epilepsy | Sinus Trouble |
| Arthritis/Osteoporosis | Hay Fever | Stomach Ulcer |
| Asthma | Hepatitis | Stroke |
| Blood Disorder | High Blood Pressure | Thyroid Problems |
| Blood Transfusion | Liver Disease | Tuberculosis |
| Cancer | Lung Disease | Venereal Disease |

Please specify any other illness not included in the above list: _____

Dental History

1. How long since your last dental check up? _____
2. Are you having any discomfort at this time? Yes No
3. Have you had:

| | | |
|--|------------------------------|-----------------------------|
| orthodontic treatment? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| periodontal (gum) treatment? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| wisdom teeth extracted? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| root canals? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| dental implants? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
4. Do your gums bleed?. Yes No
5. Do you have problems chewing? Yes No
6. Are any of your teeth sensitive or loose? Yes No
7. Do you clench or grind your teeth? Yes No
8. Do you have any pain or hear any noises in your jaw joints? Yes No
9. Does your jaw ever lock open or closed? Yes No
10. Do you have any trouble with local anesthetic (freezing)? Yes No

Patient Certification and Consent

I, the undersigned, certify that all of the above medical and dental information is true to my knowledge and I have not omitted any pertinent information. I consent to the performing of dental and oral surgery procedures agreed to be necessary or advisable including the use of local anesthetic as indicated. I will assume responsibility for fees associated with these procedures.

Patient or Parent/Guardian Signature _____ Date _____