Are you feeling dental pain or discomfort? Yes No
Have you had a medical examination in the last year? Yes No
Do you feel anxious about having dental treatment? Yes No
Have you been a patient in the hospital during the past 2 years? Yes No
Please state your physician's name _____ Phone # _____
Please list all medications you are taking _____
_____
Are you taking steroids? Yes No

**Please circle any known allergies or reactions:**

| | | | | |
|---|---|---|---|---|
| Latex | Aspirin | Darvon | Codeine | Demoral |
| Nitrous Oxide | Valium | Penicillin | Erythromycin | Tetracycline |
| Percodan | Novocain | Scopolamine | Sleeping Pills | Nembutal |
| Local Anesthetic | Other _____ | | | |

**Circle any of the following which you have had or have presently:**

| | | | | |
|---|---|---|---|---|
| Hives | Drug addiction | Heart Disease/Attack | Cough | Cobalt Treatment |
| Anemia | Rheumatism | Fainting/Dizzy spells | Angina Pectoris | Cold Sores |
| Blood Transfusion | Scarlet Fever | Diabetes | Hemophilia | Heart Surgery |
| Bruise Easily | Chemotherapy | Lung Disease | Congenital Heart Lesions | IBS/IBD |
| Fever Blisters | High Blood Pressure | Asthma | Liver Disease | Acid Reflux/Heartburn |
| Heart murmur | Hay Fever | Jaundice | Heart Pacemaker | Arthritis |
| Hepatitis A (infectious) | Heart failure | Emphysema | A.I.D.S | Kidney Trouble |
| Glaucoma | Ulcers | Sickle Cell Disease | Cosmetic Surgery | Rheumatic Fever |
| Sinus Trouble | Stomach Problems | Stroke | Cortisone Medicine | Nervousness |
| H.I.V. + | Tuberculosis | Hepatitis B (serum) | Artificial Heart Valve | Thyroid Disease |
| Venereal Disease | Artificial Joints (knee/hip) | Epilepsy/Seizures | Radiation Therapy | Sleep Apnea |

Do you have missing teeth you want replaced? Yes No
Is there anything you would change about your smile? Yes No
Explain, _____
Do you have difficulty opening or closing your mouth? Yes No
Do you have pain, clicking or popping in your jaw joints? Yes No
Are your wisdom teeth present? Yes No
If yes, do they teeth bother you? Yes No
Do you have old amalgam (silver) fillings?
Do you ever have chest pain while walking or climbing stairs? Yes No
Do your ankles swell during the day? Yes No
Have you lost or gained more than 10 pounds in the last year? Yes No
Are you on a special diet? Yes No
Do you have frequent severe headaches? Yes No
Do you have trouble sleeping? Yes No
Do you have any disease, condition, or problem not listed? Yes No
When was your last regular dental examination? _____
WOMEN ONLY: Are you pregnant? Yes No If yes, what month? _____

The undersigned hereby authorizes the doctor, upon consultation and direct consent from the patient to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs. The doctor may perform any and all forms of treatment, medications and therapy , that may be indicated in connection with (Name of Patient) _____ further to my consultation and direct consent. I understand that responsibility for payment for dental services provided for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements including insurance or otherwise, have been made.

Patient/Parent Signature _____ Date _____