



CONFIDENTIAL PATIENT INFORMATION

Please answer all questions and fill in blank spaces where indicated. Answers to the following questions are for our records only and will be strictly confidential.

MEDICAL HISTORY FOR: (NAME OF PATIENT)

- 01. Do you have a personal physician? ( ) Yes ( ) No Date of last visit: Physician's Name: Phone #:
02. Are you currently under the care of a physician? ( ) Yes ( ) No Please Explain:
03. Do you have any metal rods, pins or implants? ( ) Yes ( ) No
04. Are you taking any prescription / over-the-counter drugs? ( ) Yes ( ) No Please list each one:
05. Do you have or have you had any of the following diseases or problems? ( Please check "Y" for Yes or "N" for No )
06. Anything you would like to discuss with the dentist in private? ( ) Yes ( ) No Please list any serious medical condition(s) that you have ever had:

- 07. Are you allergic to any of the following:
( ) Yes ( ) No Aspirin ( ) Yes ( ) No Codeine ( ) Yes ( ) No Dental Anesthetics ( ) Yes ( ) No Erythromycin
( ) Yes ( ) No Jewelry / Metals ( ) Yes ( ) No Latex ( ) Yes ( ) No Penicillin ( ) Yes ( ) No Tetracycline
Please list any drugs / materials that you are allergic to:

DENTAL HISTORY:

- 01. Why have you come to the dentist today?
02. Your current dental health is ( ) Good ( ) Fair ( ) Poor
03. Does any of the following apply? ( Please check "Y" for Yes or "N" for No )
( ) Yes ( ) No Have you ever taken Phen - Phen / Redux & Pondimin? ( ) Yes ( ) No Have you ever had problem with any previous dental work?
If Yes, When? ( ) Yes ( ) No Have you ever experienced pain / discomfort in your jaw joint-TMJ?
( ) Yes ( ) No Do You require antibiotics before dental treatment? ( ) Yes ( ) No Do your gums ever bleed?
( ) Yes ( ) No Are you currently in pain? ( ) Yes ( ) No Are your teeth sensitive to heat, cold, or anything else?
( ) Yes ( ) No Have you ever had gum treatment? ( ) Yes ( ) No Do you like your smile?

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

PATIENT'S SIGNATURE: DATE:
DOCTOR'S SIGNATURE: DATE: