MEDICAL INFORMATION

1. Do you have any general health problems at this time? Yes No
   If so, please specify: _____
2. Are you presently under a physician's care? Yes No
   If so, for what reason? _____
3. Have you been hospitalized within the last five years? Yes No
   If so, for what reason? _____
4. Are you currently pregnant or nursing? Yes No
5. To the best of your knowledge, do you have or have you ever had: ***(circle yes or no for EACH item)***

Heart (Disease/Attack) / Surgery	**Yes**	**No**	Healing Complications	**Yes**	**No**
Mitral Valve Prolapse	**Yes**	**No**	Stomach Ulcers	**Yes**	**No**
Heart Murmur	**Yes**	**No**	Stroke	**Yes**	**No**
Artificial Heart Valve	**Yes**	**No**	Epilepsy/Seizures	**Yes**	**No**
Heart Pacemaker	**Yes**	**No**	Respiratory Disease / Asthma / COPD	**Yes**	**No**
Cancer/Tumor	**Yes**	**No**	Tuberculosis	**Yes**	**No**
Rheumatic Fever	**Yes**	**No**	Hip or Joint Replacement	**Yes**	**No**
High/Low Blood Pressure	**Yes**	**No**	Diabetes	**Yes**	**No**
Hepatitis	**Yes**	**No**	AIDS H.I.V. Positive	**Yes**	**No**
Prolonged / Excessive Bleeding	**Yes**	**No**	Venereal Disease	**Yes**	**No**

6. Are you taking any blood thinners/aspirin? Yes No
7. Have you had x-ray therapy, radiation or chemotherapy? Yes No
   If so, for what reason? _____
8. Do you use tobacco? Yes No
9. Are you **allergic** to any local anesthetics, drugs or medications? Yes No
   If so, please specify: _____
10. Are you currently taking any drugs or medications? _____ Yes No
    List medications _____
11. Name of Physician _____ Phone #: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____

Signature of patient, parent or guardian

DENTAL INFORMATION

Why have you come to the dentist today?

_____

Name of Previous Dentist: _____

Telephone #: _____

Date of Last Dental Visit: _____

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No

Previous Periodontal Treatment? ☐ Yes ☐ No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD) ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

How many times a week do you floss? _____

How many times a day do you brush? _____

Type of bristles? ☐ Hard ☐ Medium ☐ Soft