Name _____ Date of Birth _____

Admire Dental Care
Smile With Confidence

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes Please explain: _____
Have you ever been hospitalized or had a major operation? ☐ Yes Please explain: _____
Have you ever had a serious head or neck injury? ☐ Yes Please explain: _____
Do you use tobacco? ☐ Yes _____
Have you taken Fosamax, Aredia, Actonel, Boniva or Zometa for osteoporosis or cancer therapy? ☐ Yes _____

Women: Are you ☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics ☐ Jewelry
☐ Other If yes, please explain: _____

Do you have or have you had any of the following?

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Breathing Problem
- ☐ Cancer
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Convulsions
- ☐ Diabetes
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Fainting Spells/Dizziness
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Trouble/Disease
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ High Blood Pressure
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ MItral Valve Prolapse
- ☐ Osteoporosis
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Rheumatic Fever
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ☐ Yes Please explain: _____

List any medications you are taking (including non prescription medications): _____

Dental History

Do your gums bleed while brushing or flossing? ☐ Yes ☐ No
Are your teeth sensitive to sweets or temperature? ☐ Yes ☐ No
Have you experienced pain or difficulty opening/closing your jaw? ☐ Yes ☐ No
Are you happy with your smile and the appearance of your teeth? ☐ Yes ☐ No
Do you grind or clench your teeth? ☐ Yes ☐ No
When was your last dental visit? _____

Authorization, Consent and Release

Consent: I give my consent to the doctor and staff to take X-rays, study models, photographs or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk.

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examinations rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____ Date _____
Signature of patients (or parent/guardian of minor)