Patient's Last Name	Patient's First Name	MI	Date

MEDICAL HISTORY

Correct answers to the following questions will allow us to treat you on a more individual basis, providing the proper care for your particular needs.

Physician's Name: _____ Phone # _____

Yes	No	Check ☑ the appropriate Answer
☐	☐	Are you presently taking any medications or drugs? Blood thinners? If yes, Please list: _____
☐	☐	Are there any medications you cannot take? Or are you allergic to any medications? If yes, Please list: _____
☐	☐	Are you allergic to Latex? Local Anesthesia? Or other materials? If yes, Please list: _____
☐	☐	Have you ever had prolonged bleeding from an extraction or injury?
☐	☐	Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (Fenfluramine) and Redux (dextenfluramine).
☐	☐	Have you ever taken any osteoporosis drugs (bisphosphonates) like; Fosamax, Actonel, Boniva, Acedia, Zometa or Reclast?
☐	☐	Do you use tobacco in any form? If yes, how much? _____

Are you being treated for or have you been treated in the past for any of the following: (Circle whichever applies)

Yes	No		Yes	No		Yes	No	
☐	☐	AIDS or HIV Positive	☐	☐	Rheumatic Fever	☐	☐	Seizures, Convulsions or Epilepsy
☐	☐	Emphysema / Tuberculosis	☐	☐	Heart Murmur	☐	☐	Hepatitis
☐	☐	Asthma / Hay Fever	☐	☐	Heart Attack or Coronary Surgery	☐	☐	Venereal Disease
☐	☐	Diabetes / Thyroid Condition	☐	☐	Mitral Valve Prolapse	☐	☐	Radiation or Chemotherapy
☐	☐	High or Low Blood Pressure	☐	☐	Artificial heart valve	☐	☐	Herpes
☐	☐	Artificial joints / limbs	☐	☐	Pacemaker or Angina	☐	☐	Any Nervous condition
☐	☐	Kidney Disease / Ulcers	☐	☐	Cancer or Tumors	☐	☐	Spectrum Disorder

Please list any other health information or medical conditions, not listed above that may influence your dental treatment:

DENTAL HISTORY

Yes	No		Yes	No	
☐	☐	Do your teeth hurt when you chew?	☐	☐	Have you ever had orthodontic treatment or worn braces?
☐	☐	Do your gums bleed or hurt when you brush them?	☐	☐	Have you ever been aware of a bad odor or taste in your mouth?
☐	☐	Have you ever had gum treatments?	☐	☐	Are your teeth sensitive to hot, cold or sweets?
☐	☐	Is there any dental problem that you feel needs immediate attention? If so, please describe:	☐	☐	Do you clench or grind your teeth during the day or night?
			☐	☐	Do you floss every day? How many times?_____
			☐	☐	Have you ever had a bad dental experience?

FEMALES ONLY

Yes	No		Yes	No		Yes	No	
☐	☐	Are you now or do you think you may be pregnant?	☐	☐	Are you presently taking birth control pills?	☐	☐	Are you nursing?

AUTHORIZATION AND RELEASE:

I certify that I have read and understand the above information to the best of my knowledge. All the questions have been answered accurately. I understand that providing incorrect information can be dangerous to my health. I authorize my dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me, my child or persons under my care during the period of such dental care to third party payers and/or health practitioners.

I authorize and request my insurance company to pay directly to Parkesburg Family Dental, LLC insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services rendered.

I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____ Date: _____

(Signature of Patient, Parent, Guardian or Personal representative)

Reviewed by: _____ Date: _____

(Dentist)