
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?
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:

- | Yes | No | | Yes | No | | Yes | No | |
|--------------------------|--------------------------|----------------------------|--------------------------|--------------------------|----------------------------------|--------------------------|--------------------------|-----------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | AIDS or HIV Positive | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> | Seizures, Convulsions or Epilepsy |
| <input type="checkbox"/> | <input type="checkbox"/> | Herpes | <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack or Coronary Surgery | <input type="checkbox"/> | <input type="checkbox"/> | Ulcers |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis or | <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma / Hay Fever | <input type="checkbox"/> | <input type="checkbox"/> | Artificial heart valve | <input type="checkbox"/> | <input type="checkbox"/> | Venereal Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker or Angina | <input type="checkbox"/> | <input type="checkbox"/> | Cancer or Tumors |
| <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Condition | <input type="checkbox"/> | <input type="checkbox"/> | Artificial joints / limbs | <input type="checkbox"/> | <input type="checkbox"/> | Radiation or Chemotherapy |
| <input type="checkbox"/> | <input type="checkbox"/> | High or Low Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Sinus Problems | <input type="checkbox"/> | <input type="checkbox"/> | Any Nervous condition |

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

DENTAL HISTORY

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

FEMALES ONLY

- | Yes | No | | Yes | No | | Yes | No | |
|--------------------------|--------------------------|--|--------------------------|--------------------------|---|--------------------------|--------------------------|------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Are you now or do you think you may be pregnant? | <input type="checkbox"/> | <input type="checkbox"/> | Are you presently taking birth control pills? | <input type="checkbox"/> | <input type="checkbox"/> | 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 Lionville Dental Associates, 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)