What is the reason for your visit today?  Are your teeth sensitive to hot or cold? Yes   No   Pressure? Yes   No   Sweets? Yes   No   Do your gumb bleed when you brush? Yes   No   Do you grind or clench your teeth? Yes   No   Who was your previous Dentist? Date of last exam?  How do you like your smile? Do you have a feer of dentistry? Yes   No      MEDICAL HISTORY  Has there been any changes in your general health within the last year?  Have you been admitted to the hospital within the past two years?	Patient Name					Date	
Are your teeth sensitive to hot or cold? Yes   No   Pressure? Yes   No   Sweets? Yes   No   Do you gums bleed when you brush? Yes   No   Do you grind or clanch your teeth? Yes   No   Pate of last exam?    How do you like your smile?   Do you have a fear of dentistry? Yes   No   Pate of last exam?    How do you like your smile?   Do you have a fear of dentistry? Yes   No   Pate of last exam?		DI	ENTAL HISTORY	(C)			
Are your teeth sensitive to hot or cold? Yes   No   Pressure? Yes   No   Sweets? Yes   No   Do you gums bleed when you brush? Yes   No   Do you grind or clanch your teeth? Yes   No   Pate of last exam?    How do you like your smile?   Do you have a fear of dentistry? Yes   No   Pate of last exam?    How do you like your smile?   Do you have a fear of dentistry? Yes   No   Pate of last exam?	What is the reason for your visit today?						
Do your gums bleed when you brush? Yes   No   Do you grind or clench your teeth? Yes   No   Who was your previous Dentist?		es No D	Pressur	e? Yes No C		Sweets? Yes No No	
Who was your previous Dentist?   Do you have a fear of dentistry? Yes   No			Do you grind or	clench your teeth	? Yes	No 🔲	
MEDICAL HISTORY			, ,				
MEDICAL HISTORY   Has there been any changes in your general health within the last year?   Have you been admitted to the hospital within the past two years?							
Has there been any changes in your general health within the last year?  Have you been admitted to the hospital within the past two years?	Thow do you like your online.						
Are you been admitted to the hospital within the past two years?		MI	EDICAL HISTORY				
Are you currently under the care of a physician? Yes	Has there been any changes in your gene	eral health within	n the last year?				
Are you currently under the care of a physician? Yes	Have you been admitted to the hospital v	vithin the past to	wo years?	Yes	s 🔲 No	0	
Are you currently taking any Over-the-counter or prescription medications?							
Please List:  Do you or have you ever had any of the following disease or medical conditions: Please Check Yes or No:  A.I.D.S or HIV Infection	Physicians Name		Physicians F	hone Number			
Do you or have you ever had any of the following disease or medical conditions: Please Check Yes or No:  Al.D.S or HIV Infection	Are you currently taking any Over-the-co	unter or prescrip	otion medications?	Yes	, No		
Al.D.S or HIV Infection	Please List:			-			
Al.D.S or HIV Infection			19 1 1915	Di Obsela	V 1	NI	
Alcohol Abuse							
Allergies or Hives							
Arthritis or Painful Joints Yes   No   Glaucoma Yes   No   Pacemaker Yes   No   Artificial Joints (hip, knee) Yes   No   GERD / Acid Reflux Yes   No   Respiratory Problems Yes   No   Artificial Heart Valve Yes   No   Heart Defects / Murmer Yes   No   Radiation Therapy Yes   No   Asthma / Hay Fever Yes   No   Heart Disease / Attack Yes   No   Sinus Trouble/Surgery Yes   No   Bruise Easily Yes   No   Heart Surgery Yes   No   Stomach Ulcers Yes   No   Cancer Yes   No   Heart Surgery Yes   No   Thyroid Problems Yes   No   Cancer Yes   No   Hepatitis Yes   No   Thyroid Problems Yes   No   Diabetes Yes   No   High Blood Pressure Yes   No   Tobacco Use Yes   No   Diabetes Yes   No   Tuberculosis Yes   No   Tuberculosis Yes   No   Tuberculosis Yes   No   Sulfa Drugs Yes   No   Penicillin Yes   No   Dental Anesthetics Yes   No   Sulfa Drugs Yes   No   Seafood Yes   No   Latex Yes   No   Latex Yes   No   List any other drugs/materials you are allergic to:  Women Only: Please Check Yes or No   Are you have of the efficacy of the birth control pill when used in combination with antibiotics? Yes   No   PROVIDED CONSENT   Iunderstand 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. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent: Patient Signature		1.50					
Artificial Joints (hip, knee) Yes   No   GERD / Acid Reflux Yes   No   Respiratory Problems Yes   No   Artificial Joints (hip, knee) Yes   No   Heart Defects / Murmer Yes   No   Radiation Therapy Yes   No   Are you aware of the efficacy of the birth control pill when used in combination will be held in the strictest confidence and it is my responsibile Party Signature   Patient Signature   Responsible Party Signature   Patient Signat							
Artificial Heart Valve							
Asthma / Hay Fever							
Bruise Easily							
Cancer							
Chemotherapy	uise Easily						
Diabetes		2000/1000					
Do you have any disease or condition not listed?  Have you ever taken Phen-fen or Redux?  Are you allergic to any of the following: Please Check Yes or No  Aspirin Yes No Penicillin Yes No Dental Anesthetics Yes No   Codeine Yes No Penicillin Yes No Jewelry/Metals Yes No   Sulfa Drugs Yes No Seafood Yes No Latex Yes No   List any other drugs/materials you are allergic to:  Women Only: Please Check Yes or No  Are you pregnant? Yes No Are you Nursing? Yes No Are you taking birth control pills? Yes No Are you aware of the efficacy of the birth control pill when used in combination with antibiotics? Yes No   PROVIDED CONSENT  Iunderstand 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. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent:  Patient Signature Patient Signature Relationship to Patient		100 mm					
Are you allergic to any of the following: Please Check Yes or No Aspirin Yes No Penicillin Yes No Dental Anesthetics Yes No Sulfa Drugs Yes No Seafood Yes No Latex Yes No List any other drugs/materials you are allergic to:  Women Only: Please Check Yes or No Are you pregnant? Yes No Are you aware of the efficacy of the birth control pill when used in combination with antibiotics? Yes No PROVIDED CONSENT  Iunderstand 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. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent:  Patient Signature Date  Responsible Party Signature Relationship to Patient	Diabetes	High Blood P	ressure Yes L	INo U Tubero	culosis	Yes 🖵 No 🖵	
Are you allergic to any of the following: Please Check Yes or No  Aspirin Yes No Dental Anesthetics Yes No Dental Anesthet	Do you have any disease or cond	lition not listed?					
Aspirin Yes No Frythromycin Yes No Dental Anesthetics Yes No Codeine Yes No Penicillin Yes No Dental Anesthetics Yes No De	Have you ever taken Phen-fen or	Redux?					
Aspirin Yes No Frythromycin Yes No Dental Anesthetics Yes No Codeine Yes No Penicillin Yes No Dental Anesthetics Yes No De	Are you allergic to any of the followi	ng: Please Ched	ck Yes or No				
Codeine Yes No Penicillin Yes No Jewelry/Metals Yes No Latex Yes No Latex Yes No List any other drugs/materials you are allergic to:  Women Only: Please Check Yes or No Are you pregnant? Yes No Are you hursing? Yes No Are you taking birth control pills? Yes No Are you aware of the efficacy of the birth control pill when used in combination with antibiotics? Yes No PROVIDED CONSENT  Iunderstand 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. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent:  Patient Signature Patient Signature Relationship to Patient Relationship to Patient				Dental Anest	hetics	Yes 🔲 No 🔲	
Sulfa Drugs Yes No Seafood Yes No Latex Yes No List any other drugs/materials you are allergic to:  Women Only: Please Check Yes or No Are you pregnant? Yes No Are you Nursing? Yes No Are you taking birth control pills? Yes No Are you aware of the efficacy of the birth control pill when used in combination with antibiotics? Yes No PROVIDED CONSENT  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. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent:  Patient Signature	EAST MAIN		Yes 🗆 No 🗆	Jewelry/Meta	als	Yes 🔲 No 🔲	
List any other drugs/materials you are allergic to:  Women Only: Please Check Yes or No Are you pregnant? Yes \( \) No \( \) Are you Nursing? Yes \( \) No \( \) Are you taking birth control pills? Yes \( \) No \( \) Are you aware of the efficacy of the birth control pill when used in combination with antibiotics? Yes \( \) No \( \)  PROVIDED CONSENT  Iunderstand 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. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent:  Patient Signature \( \) Date \( \) Relationship to Patient \( \)				20 20		Yes 🗆 No 🗖	
Women Only: Please Check Yes or No  Are you pregnant? Yes \( \) No \( \) Are you Nursing? Yes \( \) No \( \) Are you taking birth control pills? Yes \( \) No \( \)  Are you aware of the efficacy of the birth control pill when used in combination with antibiotics? Yes \( \) No \( \)  PROVIDED CONSENT  Iunderstand 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. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent:  Patient Signature \( \)  Responsible Party Signature \( \)  Relationship to Patient \( \)			103 cmi 140 cmi	Latox		100 = 110 =	
Are you pregnant? Yes No Are you Nursing? Yes No Are you taking birth control pills? Yes No Provided in combination with antibiotics? Yes No Provided Consent  Inderstand 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. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent:  Patient Signature Date  Responsible Party Signature  Relationship to Patient  Relationship to Patient	List any other drugs/materials you a	re allergic to					
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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. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent:  Patient Signature Date		e birth control p	oill when used in com	bination with an	tibiotics	? Yes 🗆 No 🖵	
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the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent:  Patient Signature Date  Responsible Party Signature Relationship to Patient		ve given today is	correct to the best of n	nyknowledge. I als	so under	rstand that this information	
Responsible Party Signature Relationship to Patient	will be held in the strictest confidence an the dental staff to perform any necessary	d it is my respons dental services	sibility to inform this of that I may need during	fice of any change diagnosis and tre	es in my i atment	medical status. I authorize with my informed consent:	
Responsible Party Signature Relationship to Patient	Patient Signature		Date				
	Doctors Signature		Date				