Health History **Today's Date:______________**

Patient Name First____________________ Last ________________________M_____________ Date of Birth___________

I Please Circle Y or N for each. (Leave Blank if you do not understand the question)

1. Is your general health good? Y/N
   If NO, explain ____
2. Has there been a change in your health within the last year? Y/N
   If YES, explain____
3. Have you gone to the hospital, emergency room or had a serious illness in the last 3yrs? Y/N
   If YES, explain____
4. Are you being treated by a physician now? Y/N
   If YES, explain ____
5. Have you had problems with prior dental treatment? Y/N
   If YES, explain____
   Date of last dental exam_____________ Name of last treating Dentist________________
6. Are you in pain now? Y/N
   If YES, explain____

II Have you had or do you have any of the following? (Please circle Y or N for each)

AIDS/HIV Positive	Y/N	Cortisone Medicine	Y/N	Hemophilia	Y/N	Renal Dialysis	Y/N
Alzheimer;s Disease	Y/N	Diabetes	Y/N	Hepatitis A	Y/N	Rheumatic Fever	Y/N
Anaphylaxis	Y/N	Drug Addiction	Y/N	Hepatitis B or C	Y/N	Rheumatism	Y/N
Anemia	Y/N	Easily Winded	Y/N	Herpes	Y/N	Scarlet Fever	Y/N
Angina	Y/N	Emphysema	Y/N	High Blood Pressure	Y/N	Shingles	Y/N
Arthritis	Y/N	Epilepsy or Seizures	Y/N	Hives or Rash	Y/N	Sickle Cell Disease	Y/N
Arthritis/Gout	Y/N	Excessive Bleeding	Y/N	Hypoglycemia	Y/N	Sinus Trouble	Y/N
Artificial Heart Valve	Y/N	Excessive Thirst	Y/N	Irregular Heartbeat	Y/N	Spina Bifida	Y/N
Artificial Joint	Y/N	Fainting Spells/Dizziness	Y/N	Kidney Problems	Y/N	Stomach/Intestinal Disease	Y/N
Asthma	Y/N	Frequent Cough	Y/N	Leukemia	Y/N	Stroke	Y/N
Blood Disease	Y/N	Frequent Diarrhea	Y/N	Liver Disease	Y/N	Swelling of Limbs	Y/N
Blood Transfusion	Y/N	Frequent Headaches	Y/N	Low Blood Pressure	Y/N	Thyroid Disease	Y/N
Breathing Problem	Y/N	Genital Herpes	Y/N	Lung Disease	Y/N	Tonsillitis	Y/N
Bruise Easily	Y/N	Glaucoma	Y/N	Mitral Valve Prolapse	Y/N	Tuberculosis	Y/N
Cancer	Y/N	Hay Fever	Y/N	Pain in Jaw Joints	Y/N	Tumors or Growths	Y/N
Chemotherapy	Y/N	Heart Attack/Failure	Y/N	Parathyroid Disease	Y/N	Ulcers	Y/N
Chest pains	Y/N	Heart Murmur	Y/N	Psychiatric Case	Y/N	Venereal Disease	Y/N
Cold Sores/Fever Blisters	Y/N	Heart Pace Maker	Y/N	Radiation Treatment	Y/N	Yellow Jaundice	Y/N
Congential Heart Disorder	Y/N	Heart Trouble/Disease	Y/N	Recent Weight Loss	Y/N		

III Are you allergic to or have you had a reaction to any of the following? (Please circle Y or N for each)

1. Aspirin	Y/N	5. Metal	Y/N
2. Penicillin	Y/N	6. Latex	Y/N
3 Codeine	Y/N	7. Local Anesthetics	Y/N
4 Acrylic	Y/N	OTHER If yes, please explain:____.	

IV Woman only (Please Circle Y or N for each)

1. Are you or could you be pregnant? If YES, what month? _____________________________. Y/N
2. Are you nursing? Y/N
3. Are you taking birth control pills? Y/N

V. All patients (Please Circle Y or N for each)

1. Do you have or had any other diseases or medical problems NOT listed on this form? Y/N
   If YES, explain ____
2. Have you ever been pre-medicated for dental treatment ? Y/N
   If YES, why? ____
3. Have you ever taken Fen-Phen? Y/N
   If yes when? _______________________________________.

VI.

1. What is the reason for your visit today ?____.
2. Have you ever had an unfavorable reaction to local anesthetics (Novocaine)? Y/N
3. Have you had any serious trouble associated with previous dental treatment? Y/N
4. Do you smoke tobacco? How much? _________________. Y/N
5. Do your gums bleed when you floss or brush your teeth? Y/N
6. Do you have any problems with halitosis (Bad Breath)? Y/N
7. Have you ever been told before that you have gum disease(gingivitis or periodontitis)? Y/N
8. Do you grind or clench your teeth? Y/N
9. Have you ever been told to wear a "Nightguard", or do you wear one now? Y/N
10. Are your teeth sensitive to hot/cold or sweets? Y/N
11. Do you have a problem with food getting stuck between your fillings or restorations? Y/N
12. Are you happy with your teeth and smile? Y/N
13. Would you like your teeth to be aligned or straighter? Y/N
14. Would you like your teeth to be whiter? Y/N
15. Would you like more information on whitening procedures? Y/N
16. Are there any damaged teeth or restorations that you would like replaced? Y/N
    If yes, please indicate which area of your mouth they are located :______________________.
17. Are there missing teeth or a tooth that you would like to replace? Y/N
18. Are you interested in any cosmetic dental procedures, such as Veneers? Y/N
19. Is there any issue or condition that you would like to discuss with the Dentist in private? Y/N

The practice of dentistry involves treating the whole person. If the dentist determines that there may be A potentially medically-compromised situation, medical consultation my be needed prior to Commencement of dental treatment. I authorize the dentist to contact my physician.

Patient's Signature____**Date**______________________
Physician's Signature__________________________________**Phone Number** ___________________________

CONSENT:

1. The undersigned hereby authorizes doctor to order 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

2. 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 in connection with (name patient)________________ I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.

3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates. I understand that a 1-1/2% finance charge(18% APR) may be added to my account, in addition to any collection charges.

4. I understand that where appropriate credit bureau reports may be obtained.

5. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Patient______________________________**Date**___________________**Witness**____________________________________
Parent or Responsible Party_______________________________________ **Relationship to Patient**_________________

FOR OFFICE USE: Reviewed by Dr.____ **Date**________________