be	a or drugs age prevention age prevention age proje (or a hospital you have yes Y	s during , drugs, on drugs adverse during to had, or No	pills or herbal remess such as Fosamax preaction to any such e past five years? r have at present. Ulcers Thyroid Problem Glaucoma Contact lenses Emphysema Chronic Cough Tuberculosis Asthma	edies, include, Actonel, Ebstance or	Phone (ding regular of the second or "no" to each or "yes yes yes yes yes yes yes yes yes yes	dosages er bispho	of aspirin? Desphonates? Hepatitis A B C (circle) Venereal Disease A.I.D.S./H.I.V. Positive Cold Sores/Fever Blisters Blood Transfusion Hemophilia Sickle Cell Disease Bruise Easily	Yes	No No No No No No No No No No No No No N
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aware of having an alle olease specify	rgic (or a	during to had, or No	he past five years? r have at present. Of the present of the prese	Circle "yes"	or "no" to ea	No No No No No No No No	Hepatitis A B C (circle) Venereal Disease	Yes Yes Yes Yes Yes Yes Yes Yes	
bu been a patient in the which of the following which of the following surgery, Disease, Attack). Pain	you have . Yes	No No No No No No No No No No No	Ulcers	Circle "yes"	or "no" to ea	No No No No No No No No	Hepatitis A B C (circle) Venereal Disease	Yes Yes Yes Yes Yes Yes Yes	
Surgery, Disease, Attack) rain rain rital Heart Disease rital Heart Disease rital Heart Disease rital Heart Prosease raive Prolapse reart Valve/Pacemaker ratic Fever rheumatism rhe Medicine Ankles	Yes	No No No No No No No	Ulcers Diabetes Thyroid Problem Glaucoma Contact lenses Emphysema Chronic Cough Tuberculosis Asthma	S	Yes	No No No No No No	Hepatitis A B C (circle) Venereal Disease	Yes Yes Yes Yes Yes Yes Yes	N N N N
rain	Yes	No No No No No No No	Diabetes	S	Yes Yes Yes Yes Yes Yes Yes Yes Yes	No No No No No	Venereal Disease A.I.D.S./H.I.V. Positive Cold Sores/Fever Blisters Blood Transfusion Hemophilia Sickle Cell Disease	Yes Yes Yes Yes Yes Yes Yes	1
ital Heart Disease lurmur w Blood Pressure alve Prolapse Heart Valve/Pacemaker atic Fever /Rheumatism ne Medicine Ankles	Yes	No No No No No No	Thyroid Problem Glaucoma Contact lenses Emphysema Chronic Cough Tuberculosis Asthma	S	Yes Yes Yes Yes Yes Yes Yes	No No No No	A.I.D.S./H.I.V. Positive	Yes Yes Yes Yes Yes	1
lurmur	Yes Yes Yes Yes Yes Yes Yes Yes	No No No No No	Glaucoma Contact lenses Emphysema Chronic Cough Tuberculosis Asthma		Yes Yes Yes Yes Yes Yes Yes	No No No	Cold Sores/Fever Blisters Blood Transfusion Hemophilia Sickle Cell Disease	. Yes . Yes . Yes	1
w Blood Pressure	Yes Yes Yes Yes Yes Yes Yes	No No No No	Contact lenses Emphysema Chronic Cough Tuberculosis Asthma		Yes Yes Yes Yes	No No No	Blood Transfusion Hemophilia Sickle Cell Disease	. Yes . Yes . Yes	1
alve Prolapse	Yes Yes Yes Yes Yes	No No No	Emphysema Chronic Cough Tuberculosis Asthma		Yes Yes Yes	No No	Hemophilia	. Yes	
Heart Valve/Pacemaker atic Fever/Rheumatism ne Medicine Ankles	Yes Yes Yes	No No	Chronic Cough Tuberculosis Asthma	***************************************	Yes Yes	No	Sickle Cell Disease	. Yes	
atic Fever /Rheumatism ne Medicine Ankles	Yes Yes	No No	Tuberculosis	***************************************	Yes				
/Rheumatism ne Medicine Ankles	. Yes	No	Asthma			No	Bruise Easily	1/	
ne Medicine Ankles	. Yes							. Yes	
Ankles		No			Yes	No	Liver Disease/Yellow Jaundice	. Yes	
		No	Hay Fever/Allerg	y/Hives	Yes	No	Neurological Disorders	. Yes	
***************	. Yes	No	Latex Sensitivity	*************	Yes	No	Epilepsy or Seizures	. Yes	
	. Yes	No	Sinus Trouble		Yes	No	Fainting or Dizzy Spells	. Yes	
ecial/Restricted)	. Yes	No	Radiation Therap	у	Yes	No	Nervous/Anxious	. Yes	
Joints (hip, knee, etc.)		No	Chemotherapy		Yes	No	Psychiatric/Psychological Care.	. Yes	
Trouble		No				No	Cancer	. Yes	
									1
			dition, or problem n					Yes	1
: Are you pregnant or	think yo	ou could	be pregnant?	Yes	Months	No	Nursing? Yes No		1
stand the above info ed all questions to t respective health o ange in my health o	ormatic the bestare pro are pro	on is not of movider cation.	ecessary to pro y knowledge. S or agency, who	vide me v hould fur may rele	with denta ther inforr ase such	I care in nation I	n a safe and efficient mannoe needed, you have my pation to you. I will notify the	ner. I ha ermiss docto	ior
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stand the ed all que respectiv ange in m	above info estions to to ve health of y health of	above informations to the best ve health care property health or medical controls.	above information is nestions to the best of move health care provider by health or medication.	above information is necessary to proestions to the best of my knowledge. So we health care provider or agency, who by health or medication.	above information is necessary to provide me vestions to the best of my knowledge. Should fur we health care provider or agency, who may releasy health or medication.	above information is necessary to provide me with dental estions to the best of my knowledge. Should further informable health care provider or agency, who may release such by health or medication.	above information is necessary to provide me with dental care in estions to the best of my knowledge. Should further information live health care provider or agency, who may release such informaty health or medication.	above information is necessary to provide me with dental care in a safe and efficient mannestions to the best of my knowledge. Should further information be needed, you have my power health care provider or agency, who may release such information to you. I will notify the hy health or medication.	above information is necessary to provide me with dental care in a safe and efficient manner. I have stions to the best of my knowledge. Should further information be needed, you have my permiss we health care provider or agency, who may release such information to you. I will notify the doctory health or medication.

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.

What is the reason for your visit today?											
Date of Last Dental Visit	Last Dental Cleaning		Last Full Mouth X-rays								
What was done at your last dental visit?											
Previous Dentist's Name			Telephone								
			State Zip								
How often do you have dental examinations?											
			o you floss?								
Have you ever used or are currently using topical fluoride?											
Do you have any dental problems now? Yes No	If yes, please describ	e:									
Are any of your teeth sensitive to:			Have you ever had:								
Hot or cold?	Yes	No	Orthodontic treatment?	No							
Sweets?	Yes	No	Oral Surgery?Yes	No							
Biting or Chewing?	Yes	No	Periodontal treatment?	No							
Have you noticed any mouth odors or bad tastes?		No	Your teeth ground or the bite adjusted?Yes								
Do you frequently get cold sores, blisters or any other oral	lesions?Yes	No	A bite plate or mouth guard?Yes								
			A serious injury to the mouth or head?Yes								
Do your gums bleed or hurt?		No	Please describe, including cause								
Have your parents experienced gum disease or tooth loss		No									
Have you noticed any loose teeth or change in your bite?		No	Have you experienced:								
Does food tend to become caught in between your teeth?		No	Clicking or popping of the jaw? Yes	No							
If yes, where			Pain? (joint, ear, side of face)Yes	No							
			Difficulty in opening or closing the mouth?	No No							
Do you:	Voo	No	Difficulty in chewing on either side of the mouth?	No							
Clench or grind your teeth while awake or asleep? Bite your lips or cheeks regularly?	165 Vac	No	Sore muscles (neck, shoulders)?	No							
Hold foreign objects with your teeth? (pencils, pipe, etc.)		No	Oote madeled (neek, dhodiacid).	110							
Mouth breathe while awake or asleep?		No	Are you satisfied with your teeth's appearance? Yes	No							
Have tired jaws, especially in the morning?		No	Would you like to replace your silver fillings?								
Snore or have any other sleeping disorders?	Yes	No	Would you like to keep all of your teeth all of your life? Yes	No							
Smoke/chew tobacco or use other tobacco products?		No									
Do you feel nervous about having dental treatment?			Yes	No							
Please describe											
Have you ever had an upsetting dental experience?			Yes	No							
Please describe	dental treatment?		Yes	No							
Is there anything else about having dental treatment to lifyes, please describe			Yes	No							
ii yes, piease describe											