

MEDICAL HISTORY

Physician's Name _____ Telephone Number _____ Date of Last Visit _____

Have you ever had any serious illnesses or operations ? Yes No If yes, please describe _____

Women - Are you pregnant or think you may be ? Yes No Taking Birth Control Pills ? Yes No

Check box if you have or ever had any of the following:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia/Hemophilia | <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney/Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Fainting | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches | <input type="checkbox"/> Pace Maker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Venereal Disease |

Describe _____

Do you have any allergies to any medications ? Yes No If so What ? _____

List any medications you are currently taking: _____

Is there anything else in your medical history that we should be aware of ? _____

DENTAL HISTORY

Former Dentist Name: _____ Date of last dental visit: _____

Check box if you have any of the following:

- | | | |
|--|--|---|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Periodontal treatment |
| <input type="checkbox"/> Sensitivity to sweets | <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Grinding teeth |
| <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sensitivity biting | <input type="checkbox"/> Clicking or popping of jaw |
| <input type="checkbox"/> Broken fillings/loose teeth | <input type="checkbox"/> Sensitivity to heat | <input type="checkbox"/> Sores in mouth |

How often do you brush ? _____ How often do you floss ? _____

Why did you leave your last Dentist? _____

If there is a simple inexpensive way to lighten your teeth, would you be interested ? Yes No

If you could wave a magic wand and change one thing about your smile, what would it be ?? _____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment. I will not hold my Dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ Date: _____