PATIENT NAME		DATE	
Primary reason for this dental appointment: Examination	☐ Emergency ☐ Consultation		
Dental History			Please Circ
			\/ B1
Do you have dental examinations on a routine basis? Last visit			
Do you think you have active decay or gum disease?			
Do you brush and floss on a routine basis? Discuss			
Do your gums ever bleed? Discuss			Yes No
Do you like your smile? Why?			Yes No
Do you want to keep your remaining teeth?			
Do you ever have clicking, popping or discomfort in the jaw joint	Do you brux or grind?		Yes No
Have your past experiences in a dental office always been posi-	/e?		Yes No
Do you smoke or chew? Any sores or growths in your mouth?	iscuss		Yes No
Name of previous dentist (optional):			
Date of last full mouth x-rays (16 small films or panoramic):			
Medical History			
Are you under a physician's care now? Why?	Who?	Phone	Yes No
Have you ever been hospitalized or had a major operation? Dis Have you ever had a serious injury to your head or neck? Disc	JSS		Yes No Yes No
Are you taking any medications, aspirin, vitamins, herbals, pills of	drugs? What?		Yes No
Are you on a special diet? Discuss			
Are you allergic to any medications or substances? Please check	box below		Yes No
Aspirin Penicillin Codeine Acrylic Metal	Latex Rubber Milk Other		
Women (Please check): Pregnant/trying to get pregnant			
Do you now have or have you ever had any of the following? [you take any of these medicines? Plea	ase check appropriate boxes.	
*If yes to any of the starred conditions, please call prior to your	appointment premedication or changes	in medication may be required.	
Angina/Chest Pain Methemoglobinemia Dental Angina/Chest Pain Methemoglobinemia Dental Angina/Chest Pain Dental Altack/Failure Dental Angina/Chest Pain Dental Angina/Chest Pain Dental Angina/Chest Pain Dental Angina/Chest Pever Dental Angina/Chest Pever Dental Breathing Problem Dental Angina/Chest Pever Dental Angina/Chest Pever Dental Angina/Chest Properties Dental Angina/Chest Pever Dental Chest Pever Dental Che	phosphonates teonecrosis of Jaw Renal Dialys dia I.V. Reclast I.V. Parathyroid Dise meta I.V. Arthritis/Gou mach/Intestinal Disease Pain in Jaw ters Pain i	ems	ness
Do you wish to talk to the dentist privately about any problem			Yes No
To the best of my knowledge, all the preceding answers are correct. If I have any cha-	es in my health stalus or if my medicines change, I s	hall inform the dentist and staff at the next app	pointment without fa
X		Date	
PATIENT SIGNATURE (PARENT OR GUARDIAN)	D. In	DD D.I.	
	Date		9
History Review and Significant Findings			
Medical Updates			
I have read my MEDICAL HISTORY dated	and confirm that it adequate	ely states past and present conditi	ions.
DATE EXCEPTIONS	PATIENT'S SIGNAT		
	None 🗆	Dr	
F	None	Dr	
	None 🗆	Dr	
	None	Dr	- Varia
	None	Dr	
	None 🗆	Dr	Part and

1.5