Patient Name: ____ Date: _______________________________

Although dental personnel primarily treat the area in and around your mouth, health problems that you may have, or the medication that you may be taking, could have a significant interrelationship with the dentistry you will be receiving. Please answer the following questions carefully. Thank you!

DENTAL HISTORY

PLEASE CIRCLE "YES" or "NO"

Yes No Do you have a specific dental concern? Describe:____
Yes No Do you have dental examinations on a routine basis? Last visit:________________________________
Yes No Would you describe your present dental health as good? Comments:__________________________
Yes No Do you think you have active decay or gum disease?____
Yes No Do you ever have clicking, popping or discomfort in the jaw joints (TMJ)?___________________
Yes No Have you ever had a bad or unusual experience in a dental office?_________________________
Yes No Have you ever had oral surgery, orthodontic or periodontal treatment?_____________________
Yes No Are you pleased with the appearance of your teeth?____
Yes No Would you like to change anything about your teeth?____

____

HEALTH CONDITIONS RELATING TO DENTAL TREATMENT

Medical Doctor's Name:____________________________________ Phone #:____________________________________

Yes No Are you under a doctor's care now? Why?____
Yes No Have you been hospitalized during the past two years? Why?_______________________________
Yes No Are you allergic to any medications or substance? What?__________________________________
Yes No Are you taking any medications, pills or drugs? What?____________________________________

____

Yes No Do you take birth control pills? (Antibiotics may alter the effectiveness of birth control pills)__________________________

PLEASE ANSWER ALL QUESTIONS BY CHECKING "YES" OR "NO" IN THE APPROPRIATE BOX PROVIDED:

Yes	No		Yes	No		Yes	No	
☐	☐	Heart Trouble	☐	☐	Cancer	☐	☐	Diabetes
☐	☐	Heart Murmur	☐	☐	Chemotherapy / Radiation	☐	☐	Asthma / Emphysema
☐	☐	Rheumatic Fever	☐	☐	Kidney Trouble	☐	☐	Cortisone Medicine
☐	☐	Artificial Heart Valve	☐	☐	Liver Disease	☐	☐	Arthritis / Gout
☐	☐	Artificial Joints / Hips	☐	☐	Hepatitis	☐	☐	Tuberculosis
☐	☐	High Blood Pressure	☐	☐	Bleeding Problems	☐	☐	Herpes
☐	☐	Stroke	☐	☐	Epilepsy of Seizures	☐	☐	Allergies
☐	☐	Drug Addiction	☐	☐	AIDS	☐	☐	Psychiatric Care
☐	☐	Nervousness	☐	☐	Osteoporosis	☐	☐	Phen-Fen Treatment
☐	☐	Latex Allergy						

*Describe any other serious illness not listed above:*____
____
____

I have read my MEDICAL HISTORY and confirm that it adequately states past and present condition: ______________________

SIGNATURE OF PATIENT (PARENT OR GUARDIAN): ______________________________ **Reviewed by: Doctor**________________

DATE	CHANGES IN HEALTH / MEDICATIONS	DATE	CHANGES IN HEALTH / MEDICATIONS
__________	______________________________	__________	______________________________
	______________________________		______________________________
__________	______________________________	__________	______________________________
	______________________________		______________________________
__________	______________________________	__________	______________________________
	______________________________		______________________________

For your benefit, a thorough examination (including x-rays) is necessary before an accurate diagnosis can be reached and proper treatment rendered. I authorize Dr. Vierhus and / or Dr. Brummitt, and / or their staff to perform whatever servicesand use whatever anesthetics their professional judgement deems necessary for proper treatment. If there are any changes in my medical history, I will inform the dentist or hygienist.

____ ____
SIGNATURE OF PATIENT (PARENT OR GUARDIAN) **DATE**