**Please fill out the following information completely. Please circle all that apply**

| | | | |
|---|---|---|---|
| High Blood Pressure | Heart Attack | Rheumatic Fever | Swollen Ankles |
| Low Blood Pressure | Fainting | Asthma | Epilepsy/Seizures |
| Leukemia | Diabetes | Kidney Disease | Aids or HIV Infection |
| Thyroid Problem | Heart Disease | Cardiac Pacemaker | Heart Murmur |
| Angina | Anemia | Emphysema | Cancer |
| Joint Replacement | Arthritis | Stomach Ulcers | Chest Pains |
| Easily Winded | Stroke | Hay fever/Allergies | Tuberculosis |
| Radiation Therapy | Glaucoma | Liver Disease | Recent Weight Loss |

Respiratory Problems Mitral Valve Prolapse Other_____

Persistent Cough or throat clearing not associated with a known illness? (more than 3 weeks) Y/N

**HEIGHT:_____WEIGHT:_____PHARMACY NAME & NUMBER**:_____

Do you take bisphosphonates? (For Osteoporosis) Yes or No If yes, please list_____

Is your immune system compromised for any reason? Yes or No If yes, please explain_____

Do you PRE-MEDICATE for dental appointments? Yes or No If yes, why?_____

Are you allergic to or have you had any reactions to the following (circle all that apply)

| | | | |
|---|---|---|---|
| Local anesthesia | Sulfa Drugs | Barbiturates | Penicillin |
| Sedatives | Iodine | Aspirin | Any Metals |
| Latex Rubber | Clindamycin | Amoxicillin | Other_____ |

**Patient Medical History**

Physician_____Office Phone #_____Date of last exam_____

Are you under medical treatment now? Y/N If yes, please explain_____

_____

Have you been hospitalized for any surgical operation within the past 5 years? If yes, please explain

_____

Are you taking any prescription or non-prescription medicine? Y/N. If yes, please list below…

_____

Have you ever had a problem with anesthesia? Y/N. If yes, Please explain_____

Do you use tobacco? Y/N Do you use controlled substances? Y/N Do you wear contact lenses? Y/N

Are you pregnant or think you may be pregnant? Y/N Are you nursing? Y/N Are you taking oral contraceptives?_____

**Patient Dental History**

Name of Dentist_____Date of last exam_____

Do you feel pain to any of your teeth? Y/N. Explain_____

Do you have any sores/lumps on/in/or near your mouth? Y/N. Have you had any head, neck or jaw injuries? If yes, please explain_____

Have you experienced any of the following problems in your jaw?

Clicking? Y/N Pain? Y/N Difficulty opening/closing? Y/N Do you clench/grind your teeth? Y/N

Have you ever had difficult extractions in the past? Y/N Have you had any prolonged bleeding? Y/N

**Authorization and Release**

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I authorize the oral surgeon to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental/medical care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the oral surgeon or practice, insurance benefits otherwise payable to me. I understand that my dental/medical insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of myself or dependants.

_____

**Signature of patient, parent (if minor) or legal guardian** **Date**