Patient Name_____ Date_____

Medical History

Is the Patient in general good health currently? _____ Yes No

Is the patient presently under a physician's care? _____ Yes No

Has your physician recommended being pre-medicated prior to dental procedures? _____ Yes No

Do you currently or have you taken bisphosphonate drugs? _____ Yes No

List any drugs or medications now being taken_____

List any allergies including metal or latex_____

Please check any of the following for which the patient has been treated or diagnosed with:

[ ] Aids or other immunosuppressive disorders
[ ] Arthritis
[} Asthma
[ ] Bone disorder
[} Cancer
[ ] Diabetes
[} Ear infections (frequent)
[ ] Emotional disorders
[ ] Endocrine problems
[ ] Epilepsy or seizures
[ ] Fainting or dizziness
[ ] Heart complications
[ ] Hemophilia
[ ] Hepatitis
[ ] High or low blood pressure
[ ] HIV positive
[ ] Joint replacement
[ ] Kidney or liver disease
[ ] Rheumatic fever
[ ] Sinus trouble
[ ] Thyroid problem
[ ] Tuberculosis

Does the patient have any special conditional not listed above? _____ Yes No

Explain: _____

Females: Is the patient pregnant? _____ Yes No

Dental History

Patient's dentist _____

Has the patient had any injuries to the face, mouth, or teeth? _____ Yes No

Explain:_____

Habits: Thumb or finger sucking _____ Yes No
Mouth breathing_____ Yes No
Nail/lip biting _____ Yes No
Grinding or clenching of teeth_____ Yes No
Tongue thrusting_____ Yes No

Please make any other comments that you feel may be helpful. _____

_____

_____

I will not hold my dentist or any other member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature of parent/adult patient_____