

Patient Name: _____ Date of Birth: _____

MEDICAL HISTORY

1. Are you having pain or discomfort at this time? Yes No
2. Do you feel very nervous about having dental treatment? Yes No
3. If we could offer you a simple, inexpensive way to whiten your teeth, would you be interested? Yes No
4. If you could wave a magic wand and change one thing about your smile, what would it be? _____

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5. Have you been under the care of a medical doctor in the past two years? Yes No
 6. Are you now taking any medication, drugs, pills or herbs? Yes No
If yes, please list those drugs (including over the counter): _____
 7. Are you now or have you ever taken any BISPSPHONATE drugs (i.e., Fosomax, Boneva, Actonel)?

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8. Have you ever had any adverse reactions to any of the following?:

Aspirin	Nitrous Oxide	Penicillin	Demerol
Darvon	Valium	Erythromycin	General Anesthesia
Codeine	Percodan	Tetracycline	Vicodin / Hydrocodone
Local Anesthetic (Novocaine or Xylocaine)			

9. List any other medications or substance to which you are allergic: _____
10. Circle any of the following you have had or have at the present:

Heart Failure	Scarlet fever	Bruise Easily	Artificial Joint (knee/hip)
Heart Surgery	HIV/AIDS	Hemophilia	Arthritis
Angina Pectoria	Organ Transplant	Persistent Cough	Cancer / Tumor
Heart Attack or Disease	Anemia	Tuberculosis	Chemotherapy
Heart Murmur	Kidney Trouble	Emphysema	Radiation Treatment
High Blood Pressure	Frequent Thirst	Hay Fever	Stroke
Low Blood Pressure	Frequent Urination	Asthma	Dizzy or Fainting Spells
Artificial Heart Valve	Diabetes	Sinus Trouble	Epilepsy or Seizures
Mitral Valve Prolapse	Hepatitis A (Infectious)	Glaucoma	Rheumatic Fever
Pacemaker	Hepatitis B	Allergies / Hives	Ulcers
Psychiatric Treatment	Hepatitis C	Jaundice	Thyroid Condition
Frequent Headaches	Blood Transfusions	Liver Disease	Ankles/Legs Swelling
Clicking/Pain in Jaw	Sickle Cell Disease	Drug/Alcohol Addiction	Cold Sores
Grinding/Clenching Teeth	Other: _____		

11. When you walk up stairs or take a walk, do you ever have to stop because of pain in chest, shortness of breath, or because you are very tired? Yes No
12. Do you know or has anyone ever told you that you snore? Yes No
13. Do you ever wake up from sleep short of breath? Yes No
14. Are you on a special diet? Yes No
15. Do you smoke or chew smokeless tobacco? Yes No
16. List any other disease, condition or problem not listed: _____

17. FOR WOMEN ONLY:

Are you pregnant? Yes ___ No ___ If yes, what month? _____ Are you taking birth control pills? Yes No
Name and phone # of obstetrician: _____

Who may we thank for referring you to our office? _____

E-Mail address: _____

PATIENT'S OR GUARDIAN'S SIGNATURE: _____ DATE: _____