Medical History/Update

Today's Date:	General Health: Excellent Good Fair Poor (please circle)	
Are you currently under the care of a physician?	Yes	No
For what?		
Have you had an operation, illness or hospitalization in the last year?	Yes	No
Please explain:		
Are you taking any medications, drugs or pills?	Yes	No
Which medication? How much? How often?		
Have you been diagnosed with or treated for Sleep Apnea?	Yes	No
Is there a chance you may be pregnant?	Yes	No
Are you currently taking any birth control?	Yes	No
Are you allergic to local anesthetic, penicillin, codeine or any other drug or substance?	Yes	No
Please list allergies:		
Do you use tobacco? (cigarettes, cigars, pipe, chew) Please Circle	Yes	No
How much? How often?		

Please circle the following that apply:

Abnormal Bleeding	Mitral Valve Prolapse	Diabetes	Allergies	Seizures	Other:
Bruise Easily	Artificial Joints	Liver Disease	Difficulty Breathing	Fainting Spells	_____
Anemia	Stroke	Hepatitis Type_____	Emphysema	Glaucoma	
Sickle Cell Disease	High Blood Pressure	Yellow Jaundice	Tuberculosis	Frequent Headaches	
Artificial Heart Valve	Low Blood Pressure	Colitis	Drastic Weight Loss	HIV / AIDS	
Congenital Heart Disease	Blood Transfusion	Ulcers	Drug Abuse	Fever Blisters/Cold Sores	
Rheumatic Fever	Cancer	Thyroid Problems	Alcohol Abuse	Arthritis	
Pacemaker	Tumor History	Cosmetic Surgery	Psychiatric Problems	Venereal Disease	
Heart Murmur	Chemo / Radiation	Hay Fever	Epilepsy	Shingles	

Is there any other medical information you think we should know about that may affect treatment in any way?

Yes	No	Please explain:

Your Smile

Do you feel the appearance of your smile could be improved?	Yes	No
Please rate your smile: (hate my smile) 1____2____3____4____5____6____7____8____9____10____(love my smile)		
Please explain:		
Would you like to know what options are available to improve your smile?	Yes	No
Do you have missing teeth that haven't been replaced?	Yes	No
If missing teeth have been replaced are you unhappy with your result?	Yes	No
Would you like to know more about tooth replacement(s)?	Yes	No

Acknowledgments

To the best of my knowledge, I hereby certify the above information is accurate and true.

Patient/Guardian Signature: **Date:**

I hereby authorize necessary x-rays and other diagnostic aids deemed appropriate by the doctor in order to make a thorough diagnosis of my own or my minor dependent's needs. I further authorize the doctor to perform any treatment or administer medications that may be indicated. All of which will be explained to me prior to proceeding.

Patient/Guardian Signature: **Date:**

Office Notes: