

4. **MEDICAL HISTORY** (Please check Yes or No. If Yes, please fill in details.)

Physician _____ Phone _____

Yes No Are you allergic to any medications, latex or metal? _____

Yes No Are you currently taking any medication? _____

Yes No Do you have a history of major illness? _____

Yes No Have you had any operations or accidents? _____

Please check any of the medical conditions below that you have had or currently have:

- | | | | | | |
|--|---|---|--|---|-----------------------------------|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma or Hay Fever | <input type="checkbox"/> Bone Disorders | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Gastrointestinal Disorders | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Involvement | <input type="checkbox"/> Liver Involvement | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Pneumonia | |
| <input type="checkbox"/> Prolonged Bleeding | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tumor or Cancer | | |

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

5. **EMERGENCY INFORMATION**

Name of nearest relative not living with you _____ Relationship _____

Address _____ Phone _____

6. **DENTAL HISTORY** (Please check Yes or No. If Yes, please fill in details.)

Dentist _____ Date of Last Visit _____

What concerns you most about your teeth?

Yes No Are you presently in any dental pain? _____

Yes No Have you ever experienced any unfavorable reaction to dentistry? _____

Yes No Have you ever lost or chipped any teeth? _____

Yes No Have there ever been any injuries to face, mouth or teeth? _____

Yes No Do your gums bleed when you brush? _____

Yes No Do you have any pain or soreness around your face, neck or back? _____

Yes No Are your teeth or jaws ever uncomfortable when you awaken in the morning? _____

Yes No Are you aware of your jaw clicking or popping? _____

Yes No Have you ever been told you grind your teeth? _____

Yes No Do you have "tension" headaches, ear, eye or sinus problems? _____

Yes No Are you aware that some appointments will be during school/work hours? _____

7. **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

You may refuse to sign this Acknowledgment

I, _____, have received a copy of this office's Notice of Privacy Practices.

Signature

Date

Patient/Parent _____ Date _____