FER	ONA	LINTURNIA	IIO	(Flease Fl	THIL)	_	
Name: Mr.□ Mrs.□	J Ms.□					d m	
			(given nume)		(family name)		ame)
	mber)	er) (stree		(apt.)		(apt.)	
Date of Birth:/_/ D M Y		-	(prov.)		(postal code)		de)
Telephone: Reside		-	_ Bu	siness	_		_ Ext
Cell		Email _					
Occupation:			Re	ferred by:			
Person responsible	for the a	account: Self 🗆	Other				
Dental Insurance::	Yes 🗆	No ☐ If yes, Ir	suranc	e name			
Group/Policy No				•			
Reason for today's							
Physician: Name_				Telephone_		<u></u>	-
In case of emergence	• •	•					
Relationship			Γelepho	one			
procedures agreed t indicated and I will Patient's Signature_ Parent's Signature (	assume	responsibility fo	or fees a	issociated wit	th thos	se procedures Date	
Treatment		Treatment					11 21
8	8	Treatment	<del></del>				
7	7						
6	5						
5 4	4		-				
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4	4		a		a		(S)
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6	6		C		С		
7   8	8		d e		d e		
8	8		l e	<u> </u>	<u>e</u>		40000

MEDICAL ALEKI
Yes No  1. Are you now under the care of a physician? If so, for what treatment?
2. Have you had any serious illness or operation. Have you ever been hospitalized? If so, what was the illness or operation?
3. Are you taking any drugs or medications, vitamins or supplements?
4. Are you allergic or have you had an adverse reaction to any medication such as antibiotics, pain killers, local anesthetic, etc.
5. Do you have or have you had any of the following diseases or problems.
a) Rheumatic fever or rheumatic heart disease?
☐ ☐ b) Heart murmur?
☐ ☐ c) Artificial heart valve?
d) Congenital heart lesions?
e) Cardiovascular disease(e.g. heart trouble, heart attack, high blood pressure, hardening of the arteries, stroke?)
f) Do you experience shortness of breath or chest pains when taking a walk or climbing stairs?
☐ ☐ g) Asthma, hay fever, skin rash, or allergies?
h) Fainting spells or seizures (e.g. epilepsy)?
i) Nervous disorders?
j) Kidney disease or disorders?
k) Hepatitis, jaundice, or liver disease?
l) Endocrine disorders: e.g. thyroid disease?
m) Diabetes?
n) Glaucoma?
o) Lung or breathing disorders? e.g. tuberculosis
p) Gastrointestinal disease? e.g. ulcers
q) Bone, muscle, or joint disorders? e.g. arthritis
☐ ☐ r) Cancer?
s) Radiation or x-ray therapy?
t) Corticosteroid or steroid therapy?
u) Artificial joints?
v) Organ transplant or other medical implant? e.g. A/V shunt.
☐ ☐ w) Venereal disease?
6. Have you ever had abnormal bleeding associated with previous extractions, surgery, or trauma?
7. Do you bruise easily?
8. Do you have any blood disorder?
9. Women- Are you pregnant?
10. Do you have any other disease or problem not listed above you think we should know
about? If so, please explain.

<u>Ves No</u>								
1. How frequently have you seen your dentist	?							
When was your last visit?  2. Is there a dental problem you would like to have taken care of as soon as possible?								
2. Is there a dental problem you would like to	nave taken care of as soon as possible:							
3. Have you been given oral hygiene instruct	ion?							
4. Have you ever had local anesthetic? Any problems?								
5. Are your teeth sensitive? To what?								
6. Do your gums bleed? When?								
7. Are your gums swollen and tender?								
8. Does food catch between your teeth?								
9. Are you aware of any loose teeth?								
10. Do you object to dental x-rays?								
11. Does your jaw crack, pop or grate?								
12. Do you grind or clench your teeth?								
13. Are you concerned with the overall appearance of your teeth? What would you like to change?								
14. Do you like your smile? If not, what would you like to change?								
15. Is there anything else you would like to change about your front or back teeth?								
PATIENT CERTIFICATION AND APPROVAL								
I, the undersigned, certify that all of the above medical and dental information is true to my knowledge and I have								
not omitted any pertinent information.								
Patient(or Parent/Guardian) Date								
MEDICAL UPDATES								
	Date Changes In Medical History Signature							
<u>Date Changes In Medical History</u> <u>Signature</u>	Date Changes In Medical History Signature							
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