Are you currently If so, what are you When was your bl Do you have or h Mir Cor Dai Hig Pac Ast All	n	B No diseases	What was i s or medical c No No	t?	State	Zip Code
Medical Histo Name of Physician Address of Physic My last physical e Are you currently If so, what are you When was your bl Do you have or h Mir Cor Dai Hig Pac Ast All	n pry n cian examination was on: under medical treatment? Yes u being treated for? a being treated for? lood pressure last checked? have you had any of the following tral valve prolapse or heart murmur ngenital heart problems maged heart valves gh blood pressure	No diseases r Yes Yes	What was i s or medical c No No	t? onditions (circle yes or no): Diabetes/low blood sugar Yes		Referred By
Name of Physician Address of Physic My last physical e Are you currently If so, what are you When was your bl Do you have or h Mir Co Da Hig Pac Ast All	n	diseases r Yes Yes	What was i s or medical c No No	onditions (circle yes or no): Diabetes/low blood sugar Yes		
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My last physical e Are you currently If so, what are you When was your bl Do you have or h Mir Co Da Hig Pac Ast All	examination was on: under medical treatment? Yes u being treated for? lood pressure last checked? ave you had any of the following tral valve prolapse or heart murmu ngenital heart problems maged heart valves gh blood pressure	diseases r Yes Yes	What was i s or medical c No No	onditions (circle yes or no): Diabetes/low blood sugar Yes		
Are you currently If so, what are you When was your bl Do you have or h Mir Cor Dai Hig Pac Ast All	under medical treatment? Yes u being treated for? lood pressure last checked? ave you had any of the following tral valve prolapse or heart murmu ngenital heart problems maged heart valves gh blood pressure	diseases r Yes Yes	What was i s or medical c No No	onditions (circle yes or no): Diabetes/low blood sugar Yes		
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When was your bl Do you have or h Mir Cor Dar Hig Pac Ast All	lood pressure last checked? have you had any of the following tral valve prolapse or heart murmu- ngenital heart problems maged heart valves gh blood pressure	r Yes Yes	— s or medical c No No	onditions (circle yes or no): Diabetes/low blood sugar Yes		
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Do you have or h Mir Cor Dar Hig Pac Ast All	have you had any of the following tral valve prolapse or heart murmung ngenital heart problems maged heart valves gh blood pressure	r Yes Yes	— s or medical c No No	onditions (circle yes or no): Diabetes/low blood sugar Yes		
Mir Co Da Hig Pac Ast All	tral valve prolapse or heart murmungenital heart problems maged heart valves gh blood pressure	r Yes Yes	No No	Diabetes/low blood sugar Yes		
Co Da: Hig Pac Ast All	ngenital heart problems maged heart valves gh blood pressure	Yes	No			
Da: Hig Pac Ast All	maged heart valves gh blood pressure	Yes		riepantis of liver disease Yes	INO	
Hig Pac Ast All	gh blood pressure		No	Kidney disease Yes	No	
Ast		Yes	No	Arthritis or rheumatism Yes	No	
All	cemaker	Yes	No	AIDS or lupus Yes	No	
	thma or breathing problems	Yes	No	Ulcers or digestive problems Yes	No	
Sin	lergies and/or hives	Yes	No	Psychiatric/emotional Yes	No	
	nus trouble or hay fever	Yes	No	Blood disorders Yes	No	
Epi	ilepsy or seizures/fainting	Yes	No	Any joint replacements Yes	No	
Ple	eas <mark>e circle an</mark> d <u>list</u> any medication	ns you a	re taking:	Name of Medication		
ц;,	gh blood pressure medication	Yes	No			
111g He	art medication	Yes	No			
	ood thinners	Yes	No			
	pirin	Yes	No			
	tibiotics	Yes	No			
	eroids	Yes	No			
An	tihistamines or allergy medication	Yes	No			
	ood stabilizers or anti-anxiety drugs		No	·················		
	al Contraceptives	Yes	No			
	tritional supplements y drugs/medications not listed	Yes	No			
	e you <u>allergic</u> or have you <u>reacted</u>	d advers	ely to any of t	the following (circle ves or no):		
			<u></u> . ,		V	Na
	nicillin Yes No her antibiotics Yes No			Latex or rubber	Yes Yes	No No
	deine or Vicodin Yes No			Costume or inexpensive jewelry	res	100
	pirin Yes No			Other		

	No)			Due date:				
o you have any problems a	associate	d with you	ur menstrua	l period? Yes No				
re you nursing? Yes N	No							
re you pl <mark>a</mark> nning on nursing	g? Ye	s No						
ental History								
hat is the reason for your	visit toda	ay?						
⁷ hen was your last d <mark>e</mark> ntal e	exam?			Last cleaning?	I	Last x-rays	s?	
revious dentist?								
/hat was done at your last	dental vi	sit?	A	* A 12	_	_		
						Δ.		
o you have any dental pro	blems or	concerns	right now?_					
hat did you like least abou	ut your la	ast dental o	office?		$M_{\rm eff}$			
re any of your teeth sens	itive to (circle yes	or no):	Have you ever had (circle	e yes or 1	10):		
Hot or cold?	Yes	No	or no):	Orthodontic treatment?	Yes	No		
Hot or cold? Sweets?	Yes Yes	No No	or no):	Orthodontic treatment? Oral surgery?	Yes Yes	No No		
Hot or cold? Sweets? Biting or chewing?	Yes Yes Yes	No No No	or no):	Orthodontic treatment? Oral surgery? Gum treatment?	Yes Yes Yes	No No No		
Hot or cold? Sweets? Biting or chewing?	Yes Yes	No No	or no):	Orthodontic treatment? Oral surgery? Gum treatment? Gum surgery?	Yes Yes Yes Yes	No No No		
Hot or cold? Sweets? Biting or chewing? Brushing?	Yes Yes Yes Yes	No No No		Orthodontic treatment? Oral surgery? Gum treatment? Gum surgery? Bruxism/night guard	Yes Yes Yes Yes Yes	No No No No		
Hot or cold? Sweets? Biting or chewing? Brushing?	Yes Yes Yes Yes	No No No		Orthodontic treatment? Oral surgery? Gum treatment? Gum surgery?	Yes Yes Yes Yes	No No No		
Hot or cold? Sweets? Biting or chewing? Brushing? ave you noticed the follo	Yes Yes Yes Yes wing (cir	No No No No		Orthodontic treatment? Oral surgery? Gum treatment? Gum surgery? Bruxism/night guard TMJ appliance/bite guard	Yes Yes Yes Yes Yes Yes	No No No No No		
Hot or cold? Sweets? Biting or chewing? Brushing? Ave you noticed the follo Bleeding gums?	Yes Yes Yes Yes wing (cin	No No No rcle yes o No		Orthodontic treatment? Oral surgery? Gum treatment? Gum surgery? Bruxism/night guard TMJ appliance/bite guard Do you get frustrated beca	Yes Yes Yes Yes Yes Yes Yes	No No No No No always h		
Hot or cold? Sweets? Biting or chewing? Brushing? Ave you noticed the follo Bleeding gums? Mouth odors?	Yes Yes Yes Yes wing (cir	No No No rcle yes o No		Orthodontic treatment? Oral surgery? Gum treatment? Gum surgery? Bruxism/night guard TMJ appliance/bite guard Do you get frustrated beca new cavities or something	Yes Yes Yes Yes Yes Yes use you has to b	No No No No No always h		
Hot or cold? Sweets? Biting or chewing? Brushing? Ave you noticed the follo Bleeding gums? Mouth odors? Loose teeth?	Yes Yes Yes Yes wing (cin Yes Yes	No No No rcle yes or No No		Orthodontic treatment? Oral surgery? Gum treatment? Gum surgery? Bruxism/night guard TMJ appliance/bite guard Do you get frustrated beca	Yes Yes Yes Yes Yes Yes use you has to b	No No No No No always h		
Hot or cold? Sweets? Biting or chewing? Brushing? ave you noticed the follo Bleeding gums? Mouth odors? Loose teeth? Food trap areas?	Yes Yes Yes Wing (cin Yes Yes Yes Yes	No No No rcle yes or No No	r no):	Orthodontic treatment? Oral surgery? Gum treatment? Gum surgery? Bruxism/night guard TMJ appliance/bite guard Do you get frustrated beca new cavities or something	Yes Yes Yes Yes Yes Yes Nuse you has to b or no) Yes	No No No No No always h e repaired	d on a	10)
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Hot or cold? Sweets? Biting or chewing? Brushing? Ave you noticed the follo Bleeding gums? Mouth odors? Loose teeth? Food trap areas? o you (circle yes or no): Clench or grind your teeth Breathe through your mou	Yes Yes Yes Yes wing (cir Yes Yes Yes Yes	No No No rcle yes or No No No No	r no): Do you	Orthodontic treatment? Oral surgery? Gum treatment? Gum surgery? Bruxism/night guard TMJ appliance/bite guard Do you get frustrated beca new cavities or something frequent basis? (circle yes feel you will eventually have Yes No Do you want to control de	Yes Yes Yes Yes Yes Yes nuse you has to b or no) Yes e denture	No No No No always h e repaired No es? (circle	d on a e yes or 1	10)
Hot or cold? Sweets? Biting or chewing? Brushing? Ave you noticed the follo Bleeding gums? Mouth odors? Loose teeth? Food trap areas? to you (circle yes or no): Clench or grind your teeth Breathe through your mou Wake up with tired jaws?	Yes Yes Yes Yes wing (cir Yes Yes Yes Yes	No No No rcle yes or No No No No	r no): Do you No No No	Orthodontic treatment? Oral surgery? Gum treatment? Gum surgery? Bruxism/night guard TMJ appliance/bite guard Do you get frustrated beca new cavities or something frequent basis? (circle yes feel you will eventually have Yes No	Yes Yes Yes Yes Yes Yes nuse you has to b or no) Yes e denture	No No No No always h e repaired No es? (circle	d on a e yes or 1	10)
Hot or cold? Sweets? Biting or chewing? Brushing? Lave you noticed the follo Bleeding gums? Mouth odors? Loose teeth? Food trap areas? Do you (circle yes or no): Clench or grind your teeth Breathe through your mou Wake up with tired jaws? Smoke or chew tobacco?	Yes Yes Yes Yes wing (cir Yes Yes Yes Yes	No No No rcle yes or No No No No Yes Yes Yes Yes Yes	r no): Do you No No No No No	Orthodontic treatment? Oral surgery? Gum treatment? Gum surgery? Bruxism/night guard TMJ appliance/bite guard Do you get frustrated beca new cavities or something frequent basis? (circle yes feel you will eventually have Yes No Do you want to control de	Yes Yes Yes Yes Yes Yes nuse you has to b or no) Yes e denture	No No No No always h e repaired No es? (circle	d on a e yes or 1	10)
Hot or cold? Sweets? Biting or chewing? Brushing? Ave you noticed the follo Bleeding gums? Mouth odors? Loose teeth? Food trap areas? To you (circle yes or no): Clench or grind your teeth Breathe through your mou Wake up with tired jaws? Smoke or chew tobacco?	Yes Yes Yes Yes wing (cir Yes Yes Yes Yes	No No No rcle yes on No No No No Yes Yes Yes	r no): Do you No No No	Orthodontic treatment? Oral surgery? Gum treatment? Gum surgery? Bruxism/night guard TMJ appliance/bite guard Do you get frustrated beca new cavities or something frequent basis? (circle yes feel you will eventually have Yes No Do you want to control der your own teeth? (circle yes	Yes Yes Yes Yes Yes Yes Nuse you has to b or no) Yes e denture ntal dise s or no) Yes	No No No No always h e repaired No es? (circle ase and k No	d on a e yes or r ceep	10)
Hot or cold? Sweets? Biting or chewing? Brushing? Ave you noticed the follo Bleeding gums? Mouth odors? Loose teeth? Food trap areas? To you (circle yes or no): Clench or grind your teeth Breathe through your mou Wake up with tired jaws? Smoke or chew tobacco? Have jaw joint popping?	Yes Yes Yes Wing (cir Yes Yes Yes Yes Yes	No No No rcle yes or No No No No Yes Yes Yes Yes Yes Yes	r no): Do you No No No No No	Orthodontic treatment? Oral surgery? Gum treatment? Gum surgery? Bruxism/night guard TMJ appliance/bite guard Do you get frustrated beca new cavities or something frequent basis? (circle yes feel you will eventually have Yes No Do you want to control de your own teeth? (circle yes	Yes Yes Yes Yes Yes Yes ause you has to b or no) Yes e denture ntal dise s or no) Yes	No No No No always h e repaired No es? (circle ase and k No	d on a e yes or r xeep :	
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Hot or cold? Sweets? Biting or chewing? Brushing? Ave you noticed the follo Bleeding gums? Mouth odors? Loose teeth? Food trap areas? To you (circle yes or no): Clench or grind your teeth Breathe through your mou Wake up with tired jaws? Smoke or chew tobacco? Have jaw joint popping?	Yes Yes Yes Wing (cir Yes Yes Yes Yes Yes	No No No rcle yes or No No No No Yes Yes Yes Yes Yes Yes	r no): Do you No No No No No	Orthodontic treatment? Oral surgery? Gum treatment? Gum surgery? Bruxism/night guard TMJ appliance/bite guard Do you get frustrated beca new cavities or something frequent basis? (circle yes feel you will eventually have Yes No Do you want to control de your own teeth? (circle yes Please circle any of the fol I would like my teeth to be I do not like my silver/black	Yes Yes Yes Yes Yes Yes Yes tast o b or no) Yes e denture ntal dise s or no) Yes lowing the whiter. t fillings	No No No No always h e repaired No es? (circle ase and k No hat apply	d on a e yes or r eeep : Yes Yes	No No
Hot or cold? Sweets? Biting or chewing? Brushing? Ave you noticed the follo Bleeding gums? Mouth odors? Loose teeth? Food trap areas? To you (circle yes or no): Clench or grind your teeth Breathe through your mou Wake up with tired jaws? Smoke or chew tobacco? Have jaw joint popping? Would you like whiter teet mile? (circle yes or no) Yes	Yes Yes Yes Yes Wing (cir Yes Yes Yes Yes Yes Yes Yes Yes	No No No No No No No Yes Yes Yes Yes Yes	r no): Do you No No No No No No	Orthodontic treatment? Oral surgery? Gum treatment? Gum surgery? Bruxism/night guard TMJ appliance/bite guard Do you get frustrated beca new cavities or something frequent basis? (circle yes feel you will eventually have Yes No Do you want to control de your own teeth? (circle yes Please circle any of the fol I would like my teeth to be I do not like my silver/black I sometimes hide my teeth v	Yes Yes Yes Yes Yes Yes Yes tast o b or no) Yes e denture ntal dise s or no) Yes lowing t whiter. c fillings when I sn	No No No No always h e repaired No es? (circle ase and k No hat apply	d on a e yes or r ceep : Yes Yes Yes Yes	No No No
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Signature of Patient/Responsible Party on Account____

Date_