

**A Perfect Smile - Patient Medical History**

Patient's Full Name: \_\_\_\_\_

DOB: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
MM DD YY

**\*Have you ever had to pre-medicate for a dental procedure?**  Yes  No **If yes, do we need to prescribe?**

Check the conditions that apply to you:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Diabetes Type_____  | <input type="checkbox"/> Congenital Heart Lesions       | <input type="checkbox"/> Mental Health        |
| <input type="checkbox"/> Mitral Valve Prolapse   | <input type="checkbox"/> Cough up Blood                 | <input type="checkbox"/> Migraine Headaches   |
| <input type="checkbox"/> Heart Murmur  | <input type="checkbox"/> Epilepsy / Seizures            | <input type="checkbox"/> Neck / Head Pain     |
| <input type="checkbox"/> Artificial Joint (joint replacement, pins, rods)  | <input type="checkbox"/> Chemical Dependency            | <input type="checkbox"/> Radiation Therapy    |
| <input type="checkbox"/> Cardiovascular Disease (heart attack, angina, coronary insufficiency, coronary occusion, )_____ | <input type="checkbox"/> Hemophilia / Bleeding Disorder | <input type="checkbox"/> Scarlet Fever        |
| <input type="checkbox"/> Anemia / Blood Disease  | <input type="checkbox"/> Fainting / Nervousness         | <input type="checkbox"/> Transplant           |
| <input type="checkbox"/> Asthma  | <input type="checkbox"/> Heart Trouble                  | <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> Blood Pressure / High   | <input type="checkbox"/> Jaw Pain                       | <input type="checkbox"/> Respiratory Disease  |
| <input type="checkbox"/> Blood Pressure / Low  | <input type="checkbox"/> Pacemaker                      | <input type="checkbox"/> TMJ / Clicking Joint |
| <input type="checkbox"/> Cancer _____  | <input type="checkbox"/> Hepatitis                      | <input type="checkbox"/> Sinus                |
| <input type="checkbox"/> Chemotherapy  | <input type="checkbox"/> Herpes Virus (cold sores)      | <input type="checkbox"/> Tobacco Habit        |
|  | <input type="checkbox"/> HIV Positive / AIDS            | <input type="checkbox"/> Tonsillitis          |
|  | <input type="checkbox"/> Rheumatic Fever                | <input type="checkbox"/> Ulcer                |

If yes, describe and give approximate dates below:

Check YES or NO:

- Yes  No Are you taking blood thinners?
- Yes  No Have you ever had a blood transfusion?
- Yes  No Have you had any serious illnesses or operations

Women

- Yes  No Are you taking birth control pills?
- Yes  No Are you pregnant?
- Yes  No Are you nursing?

List any medications you are currently taking:

\_\_\_\_\_  
\_\_\_\_\_

List any food and drug allergies you have: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Are you being treated by a physician?  Yes  No If yes, please explain: \_\_\_\_\_

My primary medical physician is: \_\_\_\_\_ Phone #: \_\_\_\_\_

Dental History:

Reason for today's visit: \_\_\_\_\_ Date of last dental care: \_\_\_\_\_ Date of last dental x-rays: \_\_\_\_\_

Former dentist: \_\_\_\_\_ Former dentist's address / phone #: \_\_\_\_\_

Check if you have had problems with any of the following:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Bad breath                    | <input type="checkbox"/> Grinding teeth        | <input type="checkbox"/> Sensitivity to hot/cold        |
| <input type="checkbox"/> Bleeding gums                 | <input type="checkbox"/> Loose teeth           | <input type="checkbox"/> Sensitivity to sweets          |
| <input type="checkbox"/> Clicking / popping of jaw     | <input type="checkbox"/> Broken fillings       | <input type="checkbox"/> Sensitivity when biting        |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sores or growths in your mouth |

How often do you brush? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

Are you happy with the appearance of your teeth?  Yes  No Would you be interested in whiter teeth?  Yes  No

Have you ever had an unpleasant dental experience?  Yes  No

**Authority to Treat**

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or minor child, ever have a change in health.

I give Dr. Robert V. Nelson the authority to administer dental x-rays, local injections, anesthetics and, if requested, nitrous oxide in the subsequent treatment of my case. If I have a medical condition such as a heart murmur that requires premedication, I acknowledge that it is my responsibility to inform and remind the doctor, assistant or hygienist at the beginning of each visit.

The Doctor is not responsible for completion of treatment if I consistently fail to keep scheduled appointments.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any other member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

\_\_\_\_\_  
Patient / Guardian Signature

\_\_\_\_\_  
Date

