

Medical History

Your current physical health is: Good Fair Poor

Do you smoke or use tobacco in any other form? Yes No

Have you had any metal rods, pins or implants? Yes No

Are you taking any prescription/over the counter or herbal supplemental drugs? Yes No

Please list each one: _____

Have you ever taken Fosamax, or any other bisphosphonate? Yes No

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? Yes No

For Women:

Are you using a prescribed method of birth control? Yes No

Are you pregnant? Yes No

Are you nursing? Yes No

Have you ever had any of the following diseases or medical problems?

Y N Abnormal Bleeding	Y N Herpes/Fever Blisters
Y N Alcohol/Drug Abuse	Y N High Blood Pressure
Y N Anemia	Y N HIV+/AIDS
Y N Arthritis	Y N Hospitalized for any reason
Y N Artificial Bones/joins/valves	Y N Kidney Problems
Y N Asthma	Y N Liver Disease
Y N Blood Transfusion	Y N Low Blood Pressure
Y N Cancer/Chemotherapy	Y N Lupus
Y N Colitis	Y N Mitral Valve Prolapse
Y N Congenital Heart Defect	Y N Osteoporosis/Paget's Disease
Y N Diabetes	Y N Pacemaker
Y N Difficulty Breathing	Y N Psychiatric Treatment
Y N Emphysema	Y N Radiation Treatment
Y N Epilepsy	Y N Rheumatic/Scarlet Fever
Y N Fainting Spells	Y N Seizures
Y N Frequent Headaches	Y N Shingles
Y N Glaucoma	Y N Sickle Cell Disease/Traits
Y N Hay Fever	Y N Sinus Problems
Y N Heart Attack	Y N Stroke
Y N Heart Murmur	Y N Thyroid Problems
Y N Heart Surgery	Y N Tuberculosis (TB)
Y N Hemophilia	Y N Ulcers
Y N Hepatitis	Y N Venereal Disease

Please list any serious medical condition(s) that you have ever had:

Are you allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Tetracycline
Y N Codeine	Y N Latex	Y N Other
Y N Dental Anesthetics	Y N Penicillin	

Please List any other drugs/materials that you are allergic to: _____

Dental History

Why have you come to the dentist today? _____

Do you require antibiotics before dental treatment? Yes No

Are you currently in pain? Yes No

Have you ever had a serious/difficult problem associated with any previous dental work? Yes No

Do you have fears about going to the dentist? Yes No

Have you ever had gum treatment? Yes No

Do you now or have you ever experienced pain/ discomfort in your jaw joint? Yes No

Your current dental health is: Good Fair Poor

Do you like your smile? Yes No

Do your gums ever bleed? Yes No

How many times a week do you floss? _____ a day do you brush? _____

Type of bristles? Soft Medium Hard

How long do you use a toothbrush before replacing it? _____

Are your teeth sensitive to heat, cold, or anything else? Yes No

Have you lost any teeth? Yes No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature _____ Date _____

Payment is due in full at the time of treatment Unless prior arrangements have been approved

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. All treatment plans for future dental work are estimated per your insurance coverage I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature _____ Date _____

Our office is HIPPA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Consent to Dental Photography: I authorize New Lenox Dental Group to take photographs, and/or videos of my face, jaws, and teeth, before, during and after treatment. I consent to allow the photographs to be used for:

- Dental Records and Dental Research,
- Dental Education including lectures, seminars, demonstrations, professional publications such as journals or books
- Marketing material, including websites and printed materials, patient education.

I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs.

Signature (Patient or Guardian) _____ Date: _____

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I verbally reviewed the medical/dental information above with the patient named herein. Initials: _____ Date: _____