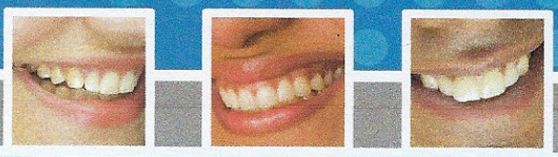
engddsinc@gmail.com



Medical & Dental History Form

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Do you have any of the following diseases or problems: Active Tuberculosis? Persisten cough greater than a 3 week duration? Cough that produces blood? Been exposed to anyone with tuberculosis? If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

* ◯ Yes ◯ No

Within the past year, have there been any changes in your general health?

◯ Yes ◯ No

Would you consider yourself to be in fairly good health?

◯ Yes ◯ No

What is the date (or approximate date) of your last medical exam?

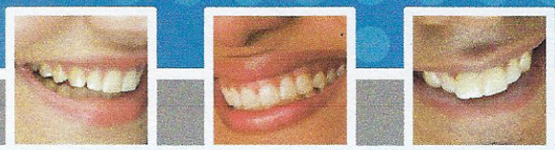
Your Primary Care Physician's name, address, & phone number:

Have you had an orthopedic total joint (hip, knee, elbow, finger) replcaement? Date:_____ If yes, have you had any complications?_____

◯ Yes ◯ No

Are you taking, have taken or scheduled to begin taking Bisphosponates for osteoporosis, multiple myeloma or other cancers?
(Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa)

◯ Yes ◯ No



Please mark any of the following to indicate Yes in response to the question:

- ☐ Have you ever had complications following dental treatment?
- ☐ Are you currently under the care of a physician due to a specific condition?
- ☐ Have you been hospitalized within the last 5 years due to a surgery or illness?
- ☐ Are you currently taking any prescription or non-prescription medications?
- ☐ Do you use tobacco (smoking or chewing)?
- ☐ Do you require the use of corrective lenses (contacts or glasses)?
- ☐ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

If any of the previous questions are marked, please explain:

WOMEN ONLY: Are you pregnant?

◯ Yes ◯ No

If Yes, when is the due date?

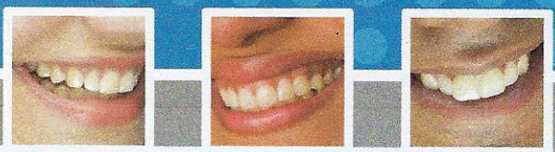
Please list all medications:

Answer Yes or No

☐ YES___ NO___

☐ AIDS	☐ Amoxicillin Allergy	☐ Anemia
☐ Angina	☐ Antidepressent	☐ Arthritis
☐ Artificial Joints	☐ Asthma Inhalers	☐ Asthma
☐ Atenolol	☐ Atorbastatin	☐ Autism
☐ Baby Aspirin	☐ Bisphosphanate	☐ Blood Disease

engddsinc@gmail.com



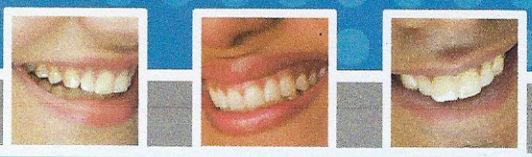
- [ ] Boniva
- [ ] Cancer
- [ ] Cholesterol Meds
- [ ] Codeine Allergy
- [ ] Coumadin Patient
- [ ] Crohns Disease
- [ ] Diabetes
- [ ] Dizziness
- [ ] Epilepsy
- [ ] Erthyromycin Allergy
- [ ] Excessive Bleeding
- [ ] Fainting
- [ ] Fosamax
- [ ] Glaucoma
- [ ] Hay Fever
- [ ] Head Injuries
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] Iodine Allergy
- [ ] Jaundice
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Mental Disorders
- [ ] Nervous Disorders
- [ ] Osteoporosis
- [ ] Pacemaker
- [ ] Peanut Allergy
- [ ] Penicillin Allergy
- [ ] Pre-Med
- [ ] Radiation Treatment
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] See List of Meds.
- [ ] Seizures
- [ ] Sinus Problems
- [ ] Sjogren(Dry Mouth)
- [ ] Sleep Disorder
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Sulfa Drug Allergy
- [ ] Thyroid Meds
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Ulcers
- [ ] Venereal Disease
- [ ] Zometa

Do you have any other health issues or allergies?

What is the reason for your dental visit today?

When was your last visit to the dentist (if to a different office)?

What was done on your last dental visit (if to a different office)?



Prior Dentist's name, address, & phone number:

How frequently do you brush your teeth?

○ 3 (+) a day ○ Twice a day ○ Once a day ○ Weekly ○ Seldom

How frequently do you floss your teeth?

○ 1 (+) a day ○ 2 - 6 weekly ○ 1 - 6 monthly ○ Seldom ○ Never

Please mark any of the following to indicate Yes in response to the question:

☐ Do your gums bleed when you brush or floss?

☐ Do your teeth experience sensitivity to cold or hot temperatures?

☐ Are any of your teeth currently causing you pain?

☐ Do you grind your teeth (either consciously or during sleep)?

☐ Are any of your teeth loose, or are you concerned about any teeth loosening?

☐ Do you currently have any dental implants, dentures, or partials?

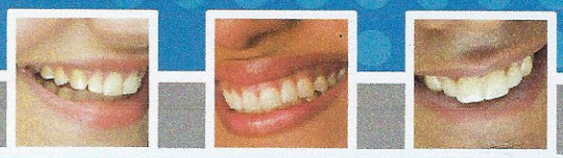
If any of the previous questions are marked, please explain:

If you could change anything about your mouth, teeth, or smile, what would it be?

☐ To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next detal appointment without fail.

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.



I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian:

Signature: _____ Date: _____

Relationship to Patient:

_____

Response Date: _____