

Patient's Name: _____ Date of Birth: _____ Date: _____

Physician: _____ Physician's Phone: _____

Date of Last Physical Exam _____ Your current health is Good Fair Poor

List any medications being taken:

List any allergies to any medications:

Other Allergies? Latex Metals Other _____

Women Only – Are you Pregnant? Yes No; if yes when is the expected date? _____

Do you use tobacco? Yes No; if yes, which form? _____

Have you ever been hospitalized? Yes No; if yes, please explain _____

Do you use any recreational drugs? Yes No; if yes, please explain _____

	Yes	No		Yes	No		Yes	No
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Problems	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever/Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Fainting/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Valve	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Stents	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joint/Limbs	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Circulation Problems	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Troubles/Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>

Comments: _____

Dental History

Have you ever been medicated for dental treatment? Yes No; if yes, please describe _____

How do you describe your dental health? Good Fair Poor Home care: Brush? Yes No Floss? Yes No

Do you like your smile? Yes No Are your teeth sensitive? Yes No; if yes, please describe _____

Have you ever had any of the following?

	Yes	No		Yes	No		Yes	No
Bad Breath	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>	Snoring	<input type="checkbox"/>	<input type="checkbox"/>
Periodontal Treatment	<input type="checkbox"/>	<input type="checkbox"/>	Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>	Swelling	<input type="checkbox"/>	<input type="checkbox"/>
Blister or sores	<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain or tiredness	<input type="checkbox"/>	<input type="checkbox"/>	Gums swollen or tender	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping Problems	<input type="checkbox"/>	<input type="checkbox"/>	Pain around Ear	<input type="checkbox"/>	<input type="checkbox"/>	Grinding Teeth	<input type="checkbox"/>	<input type="checkbox"/>
Food between teeth	<input type="checkbox"/>	<input type="checkbox"/>	Mouth Breathing	<input type="checkbox"/>	<input type="checkbox"/>	Orthodontic Treatment	<input type="checkbox"/>	<input type="checkbox"/>

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize Dr. Szeto to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to Dr. Szeto or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient (or parent/guardian if minor) _____ Date _____

Initial B.P. _____ Signature of Doctor _____ Date _____

Medical History