Medical History :

Date of your last health care _____ What for _____
Have you been hospitalized (for surgery or severe illness)? If yes, when _____what for _____
Name of your physician _____ Phone _____

Do you have or have you ever had :

Yes	No		Yes	No	
___	___	Rheumatic Fever	___	___	Anemia
___	___	Heart Murmur	___	___	Diabetes
___	___	Abnormal Heart Condition	___	___	Epilepsy
___	___	Abnormal Blood Pressure	___	___	Hepatitis
___	___	Abnormal Bleeding From a Cut	___	___	AIDs or Veneral Disease
___	___	Artificial Joint or Heart Valve	**Do you have allergies to :**		
___	___	Do You Smoke	___	___	Penicillin
___	___	Do You Consume Alcohol	___	___	Local Anesthetic
___	___	(woman): Are You Pregnant Now	___	___	Latex

If allergies to other medication, drugs or food, indicate which ones _____
Other physical conditions you should let us know _____
Have you ever take any Weight Loss drugs which contains Phen-Phen _____
Are you taking any medication now? Yes ___ No ___ If yes, please list _____

Dental History :

Name of Former Dentist _____ Phone _____

Do you have or have you ever had :

Yes	No	
___	___	Do you make regular dental visit?
		Date of your last visit _____ what for _____
		Any full mouth x-rays with 3-5 years _____ Same Insurance____
___	___	Have you had your tooth/teeth extracted by Dentist(s)?
___	___	Are your teeth sensitive to temperature (__ hot, __ cold or __ sweet ...)?
___	___	Do you feel sore in your teeth/mouth while biting or chewing?
___	___	Do your gum bleed when brushing?
___	___	Do you use dental floss regularly?
___	___	Do you like your appearance of teeth? If no, why _____
___	___	Do you clench or grind your teeth at sleep (bruxism)?
___	___	Does your jaw click or pop when opening your mouth?
___	___	Have you ever had any special dental work done?
		___Braces ___ Gum surgery ___ Maxillo-facial surgery ___ Implant
		If so, When _____ Name of dentist _____

I certify that the above and reverse side of information are complete and accurate. I also hereby **consent** to the treatment indicated on my examination form, including the use of any anesthetics, sedatives, medicament, or X-rays, as may be deemed necessary by the Doctor(s) in Mission Valley Dental Center. I will also notify Doctor(s) anytime of any change in my health status or the above information. Besides, I understand and agree that (Regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional services rendered.

Signature (patient, or parent/guardian if minor) _____ Date _____

Reviewed by Doctor (treating dentist) _____ Date _____