

DENTAL ASSOCIATES - MEDICAL HISTORY FORM PAGE 2

Patient Name:

5. List any medication you are currently taking (include over-the-counter medicine/aspirin):

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

6. List any allergies (Especially: Penicillin, Aspirin, Codeine, or Latex): _____

7. Do you smoke? Yes / No If yes, how much? _____

* If you could change one thing about your smile, what would it be? _____

* Would you be interested in a simple, effective way to whiten your smile? Yes No

WOMEN ONLY PLEASE ANSWER: Y = YES or N = NO

Are you pregnant? _____ If yes, how long? _____ Are you nursing? _____

Are you taking birth control pills? _____

Are you experiencing post-menopausal disorders such as Osteoporosis? _____ If yes, please explain:

I FULLY UNDERSTAND THAT FOR DENTAL ASSOCIATES TO ADMINISTER PROPER DENTAL TREATMENT, I MUST KEEP DENTAL ASSOCIATES AWARE OF ANY CHANGES IN MY HEALTH AND, TO THE BEST OF MY KNOWLEDGE, ALL THE PROCEEDING ANSWERS ARE CORRECT.

Patient Signature _____ **Reviewers Initials** _____ **Date** _____

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