Do you smoke or use other forms of tobacco? ☐ Yes ☐ No _____

Do you have a history of alcohol and/or drug use or abuse? ☐ Yes ☐ No _____

Have you received treatment for alcohol or drug use or abuse? ☐ Yes ☐ No _____

Do you currently have, or have you had in the past, any disease, condition or problem not listed? ☐ Yes ☐ No

If yes, please explain. _____

Is there any problem or medical condition that you wish to discuss in private only? ☐ Yes ☐ No

WOMEN ONLY: Are you pregnant or suspect you might be? ☐ Yes ☐ No Anticipated delivery date? _____

Are you breast feeding? ☐ Yes ☐ No _____

Are you taking any birth control pills? ☐ Yes ☐ No _____

NOTE: IT IS IMPORTANT THAT ANY CHANGES IN YOUR HEALTH STATUS BE REPORTED TO OUR OFFICE.

I confirm that all of the medical and dental information provided above is true to the best of my knowledge, and I have not omitted any information. I also consent to my physician being contacted if necessary to obtain any information that is required for my dental care.

Signature _____ Date _____

☐ *Patient* ☐ *Parent* ☐ *Legally Authorized Representative*

Reviewed by dentist _____ Date _____