Evan G. Young, DDS, dba Midnight Sun Smiles, LLC 2000 Abbott Road, Suite 100 Anchorage, Alaska 99507

MEDICAL HISTORY

PATIENT NAME_____ Birth date_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is an integral part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ❑Yes ❑No If yes, Physician's name:_____
Have you ever been hospitalized or had a major operation? ❑Yes ❑No If yes, describe:_____
Have you ever had a serious head or neck injury? ❑Yes ❑No If yes, please explain:_____
Are you taking any medications, supplements or drugs? ❑Yes ❑No If yes, please list:_____
Do you have a history of snoring? ❑Yes ❑No If yes, please explain:_____
Have you been diagnosed with obstructive sleep apnea? ❑Yes ❑No If yes, please explain:_____
Do you clench or grind your teeth? ❑Yes ❑No If yes, please explain:_____
Are you on a special diet? ❑Yes ❑No If yes, type of diet:_____
Do you consume alcohol? ❑Yes ❑No If yes, ❑ Beer ❑ Liquor ❑ Wine # Drinks per week:_____
Do you use tobacco of any kind? ❑Yes ❑No If yes, ❑ Smoke ❑ Chew Tobacco ❑ Snuff ❑ E-cig/Vape Pen
Do you use marijuana? ❑Yes ❑No If yes, ❑ Smoke ❑ Edible ❑ Vaping ❑ Other:_____
Do you use controlled substances? ❑Yes ❑No If yes, name of substance:_____

Women: Are you

❑ Pregnant? ❑ Nursing?
❑ Trying to get pregnant? ❑ Taking oral contraceptives?

Pre-Meds

Taking an antibiotic pre-med? ❑Yes ❑No Med_____
Reason for pre-med:_____

Are you allergic to any of the following?

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex ❑ Local Anesthetics

❑ Sulfa Drugs ❑ Other If yes, please explain:_____

Do you have, or have you had, any of the following? If yes, please explain below.

❑ AIDS/HIV Positive	❑ Chemotherapy	❑ Frequent Headaches	❑ Kidney Problems	❑ Sickle Cell Disease
❑ Alzheimer's Disease	❑ Chest Pains	❑ Genital Herpes	❑ Leukemia	❑ Sinus Trouble
❑ Anaphylaxis	❑ Cold Sores/Fever Blisters	❑ Glaucoma	❑ Liver Disease	❑ Spina Bifida
❑ Anemia	❑ Congenital Heart Disorder	❑ Hay Fever	❑ Low Blood Pressure	❑ Stomach/Intestinal Disease
❑ Angina	❑ Cortisone Medicine	❑ Heart Attack/Failure	❑ Lung Disease	❑ Stroke
❑ Arthritis/Gout	❑ Diabetes (I/II) (HbA1c:_____)	❑ Heart Murmur	❑ Mitral Valve Prolapse	❑ Swelling of the Limbs
❑ Artificial Heart Valve	❑ Drug Addiction	❑ Heart Pacemaker	❑ Pain in the Jaw Joints	❑ Thyroid Disease
❑ Artificial Joint	❑ Dry Eyes	❑ Hemophilia	❑ Parathyroid Disease	❑ Tonsillitis
❑ Asthma (last attack:_____)	❑ Dry Mouth/ Excessive Thirst	❑ Hepatitis A	❑ Psychiatric Care	❑ Tuberculosis
❑ Blood Disease	❑ Easily Winded	❑ Hepatitis B	❑ Radiation Treatments	❑ Tumors or Growths
❑ Blood Transfusion	❑ Emphysema	❑ Hepatitis C	❑ Recent Weight Loss	❑ Ulcers
❑ Breathing Problems	❑ Epilepsy or Seizures	❑ Herpes/HPV	❑ Renal Dialysis	❑ Sexually Transmitted Disease
❑ Bruise Easily	❑ Excessive Bleeding	❑ High Blood Pressure	❑ Rheumatic Fever	❑ Yellow Jaundice
❑ Cancer (type:_____)	❑ Fainting Spells/Dizziness	❑ High Cholesterol	❑ Rheumatism	
❑ Cardiovascular Disease	❑ Frequent Cough	❑ Hives or Rash	❑ Scarlet Fever	
(Type:_____)	❑ Frequent Diarrhea	❑ Irregular Heartbeat	❑ Shingles	

Diagnosed with *osteoperosis* or *metastatic bone cancer*? ❑ Yes ❑ No. Are you now or have you ever taken **Bisphosphonate or Rank Ligand Inhibitor** medications such as (check all that apply) ❑ Didronel(Orally), ❑ Skelid(Orally), ❑ Fosamax(Orally), ❑ Actonel(Orally), ❑ Boniva(Orally),❑ Aredia(IV), ❑ Zometa(IV) or ❑ Denosumab/Prolia (injected)? ❑ Yes ❑ No. If so, for how long? __ ❑ days, ❑ months, ❑ years and at what dosage (if known)? _____ mg ❑ 1X, ❑ 2X, ❑ 3X, ❑ 4X…❑ daily or ❑ weekly. When was the last dosage taken? _____

Have you ever had any serious illness not listed above or require further explanation? ❑Yes ❑No If yes, please explain:_____

_____

Acknowledgement and Consent

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform this dental office of any changes in my (patient's) medical status.

My signature below acknowledges my receipt of the brochures entitled "*Our Office*" (Form OO, Edition Date 7/1/2012), "*Financial Policies*" (Form FP, Edition Date 7/1/2012), "*Notice of Privacy Practices"* (Form PP, Edition Date 7/1/2012), *"Bisphosphonate Induced Osteonecrosis of the Jaws" if applicable* (Form BP, Edition Date 7/1/2012), *"Informed Consent for Dental Treatment",* (Form IC, Edition Date 7/1/2012) and that I have had full opportunity to read, understand and consider the contents and implications of the information provided in these brochures. I understand that by signing this form, I agree to abide by the published financial policies of this office and hereby give my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations as described in the *"Notice of Privacy Practices"* brochure. In addition, I read, write and communicate in the English language.

My initials in the space that follows also gives my consent for this office to bill my insurance for services rendered with benefits made payable to this office. We will keep this signature on file for future insurance claims. Initials:_____

Signed:_____ Date:_____

Patient, Parent or Legal Guardian (Must be 18 years or older)