

**ESTHETIC EXCELLENCE**  
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OLATHE, KS 66062  
913-829-9222

**HEALTH HISTORY**

How long since you have been to a dentist?

What was done at this appointment?

Did you make regular visits to the dentist before then?

How often do you brush your teeth?

Do you floss?

Is another member of your family a patient at our office?

Women – Are you pregnant?  Yes  No      If Yes, Due Date?

Are you allergic to:       Penicillin    Codeine    Local Anesthetic    Latex    Sulfa    Erythromycin  
 Other – If so, please specify:

**Please check if you have ever had:**

Heart Disease	<input type="checkbox"/> Yes	Epilepsy	<input type="checkbox"/> Yes	Liver Disease	<input type="checkbox"/> Yes
Heart Murmur	<input type="checkbox"/> Yes	Respiratory Problems	<input type="checkbox"/> Yes	Asthma	<input type="checkbox"/> Yes
Rheumatic fever	<input type="checkbox"/> Yes	Anemia	<input type="checkbox"/> Yes	Sinus trouble	<input type="checkbox"/> Yes
Congenital heart defects	<input type="checkbox"/> Yes	Thyroid problem	<input type="checkbox"/> Yes	Cancer	<input type="checkbox"/> Yes
Abnormal Aeortic Valve	<input type="checkbox"/> Yes	Chemical dependency	<input type="checkbox"/> Yes	Stroke	<input type="checkbox"/> Yes
Mitro Valve Prolapse	<input type="checkbox"/> Yes	Artificial joints	<input type="checkbox"/> Yes	TMJ (jaw/joint pain)	<input type="checkbox"/> Yes
Artificial heart valve	<input type="checkbox"/> Yes	Excessive bleeding	<input type="checkbox"/> Yes	Radiation therapy	<input type="checkbox"/> Yes
Heart pacemaker	<input type="checkbox"/> Yes	Fainting spells	<input type="checkbox"/> Yes	Psychiatric care	<input type="checkbox"/> Yes
Pre-Med	<input type="checkbox"/> Yes	Jaundice	<input type="checkbox"/> Yes	Prosthetic implant	<input type="checkbox"/> Yes
Abnormal blood pressure	<input type="checkbox"/> Yes	Hepatitis (Type A)	<input type="checkbox"/> Yes	Bruise easily	<input type="checkbox"/> Yes
Ulcers	<input type="checkbox"/> Yes	Leukemia	<input type="checkbox"/> Yes	HIV	<input type="checkbox"/> Yes
Tuberculosis or lung disease	<input type="checkbox"/> Yes	Kidney Disease	<input type="checkbox"/> Yes	AIDS	<input type="checkbox"/> Yes
Diabetes	<input type="checkbox"/> Yes				
Excessive urination or thirst	<input type="checkbox"/> Yes				

Do you ever experience bleeding gums when brushing or flossing?       Yes    No

Are you having pain or discomfort at this time?       Yes    No

Do you feel apprehensive about having dental treatment?       Yes    No

Have you ever had a bad experience in the dental office?       Yes    No

Have you been under the care of medical doctor during the past two years?       Yes    No

Are you now taking any medication, drugs, or pills?       Yes    No

If yes, please specify:

I hereby authorize the above named dentist(s) to provide any insurance company(s), claim administrator(s), and consulting health care professionals information concerning health care, advice, treatment, or supplies provided. This information will be used exclusively for the purpose of evaluating and administering claims for benefits.

Patient or Authorized Guardian's signature and Date