

Dental History

What would you like us to do today? _____ Are you in dental discomfort today? _____

Former Dentist _____ Address _____ Phone _____

Date of last dental care _____ Date of last x-rays _____

Check (✓) if you have had problems with any of the following:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Grinding or clenching teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to hot | <input type="checkbox"/> Sores or growths in mouth |

How often do you brush? _____ Floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? Y N

Other information about your dental health or previous treatment _____

Medical History

Physician's name _____ Phone _____

Date of last visit _____ Have you had any serious illnesses or operations? Y N

If yes, describe _____

Are you currently under physician care? Y N If yes, describe _____

Have you ever had a blood transfusion? Y N If yes, give approximate dates _____

Women: Are you pregnant? Y N Nursing? Y N Taking birth control pills? Y N

Check (✓) if you have had any of the following:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Cough, persistent | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic/Scarlet fever |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Cough up blood | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw pain | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney disease or malfunction | <input type="checkbox"/> Skin rash |
| <input type="checkbox"/> Artificial heart valves | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Artificial joints | <input type="checkbox"/> Food allergies | <input type="checkbox"/> Material allergies (latex, wool, metal, chemicals) | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Surgical implant |
| <input type="checkbox"/> Atopic (allergy prone) | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nervous problems | <input type="checkbox"/> Swelling of feet or ankles |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Pacemaker/Heart surgery | <input type="checkbox"/> Thyroid disease or malfunction |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Tobacco habit |
| <input type="checkbox"/> Cancer | Describe _____ | <input type="checkbox"/> Rapid weight gain or loss | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Hemophilia/Abnormal bleeding | <input type="checkbox"/> Radiation treatment | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Herpes | <input type="checkbox"/> Respiratory disease | <input type="checkbox"/> Ulcer/Colitis |
| <input type="checkbox"/> Circulatory problems | | | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Cortisone treatments | | | |

List medications you are currently taking, if any:

List drug allergies, if any:

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.