DENTAL HISTORY

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

Former Dentist _____ Address _____

Dentist's Email _____ Phone _____

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

Check ( ) yes or no if you have problems with any of the following:

☐ Y ☐N Bad breath
☐ Y ☐N Bleeding gums
☐ Y ☐N Clicking or popping jaw
☐ Y ☐N Periodical treatment
☐ Y ☐N Sensitiviy to cold
☐ Y ☐N Sensitivity to hot
☐ Y ☐N Food collection between teeth
☐ Y ☐N Grinding or clenching teeth
☐ Y ☐N Loose teeth or broken fillings
☐ Y ☐ N Sensitivity to sweets
☐ Y ☐N Sensitivity when biting
☐ Y ☐N Sores or growths in mouth

How often do you brush? _____ Floss?_____

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

Have you 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 transfusions? ☐ Y ☐ N If yes, give approximate dates _____

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

Have you ever taken Fen-Phen/Redux? ☐Y ☐ N

Check boxes yes or no if you have had any of the following:

☐Y ☐N AIDS/HIV Positive
☐Y ☐N Anaphylaxis
☐Y ☐N Anemia
☐Y ☐N Arthritis, Rheumatism
☐Y ☐N Artificial heart valves
☐Y ☐N Artificial joints
☐Y ☐N Astma
☐Y ☐N Atopic (allergy prone)
☐Y ☐N Back problems
☐Y ☐N Blood disease
☐Y ☐N Cancer
☐Y ☐N Chemical dependency
☐Y ☐N Chemotheraphy
☐Y ☐N Circulatory problems
☐Y ☐N Cortisone treatments
☐Y ☐N Cough, persistent
☐Y ☐N Cough up blood
☐Y ☐N Diabetes
☐Y ☐N Epilepsy
☐Y ☐N Fainting
☐Y ☐N Food allergies
☐Y ☐N Glaucoma
☐Y ☐N Headaches
☐Y ☐N Heart murmur
☐Y ☐N Heart problems
Describe _____
☐Y ☐N Hemophilia/Abnormal Bleeding
☐Y ☐N Herpes
☐Y ☐N Hepatitis
☐Y ☐N High blood pressure
☐Y ☐N Jaw pain
☐Y ☐N Kidney disease or malfunction
☐Y ☐N Liver disease
☐Y ☐N Material allergies (latex, wool,) metal, allergies)
☐Y ☐N Mitral valve prolapse
☐Y ☐N Pacemaker/Heart Surgery
☐Y ☐N Psychiatric care
☐Y ☐N Rapid weight gain or loss
☐Y ☐N Radiation treatment
☐Y ☐N Respiratory disease
☐Y ☐N Rheumatic/Scarlet fever
☐Y ☐N Shingies
☐Y ☐N Skin rash
☐Y ☐N Stroke
☐Y ☐N Swelling of feet or ankles
☐Y ☐N Thyroid disease or malfunction
☐Y ☐N Tuberculosis
☐Y ☐N Veneral disease
☐Y ☐N Cortisone treatments
☐Y ☐N Spina Bifida
☐Y ☐N Surgical implant
☐Y ☐N Tonsillitis
☐Y ☐N Tobacco habit
☐Y ☐N Ulcer/Colitis

Are you currently taking any medications? If yes, list all:

_____
_____
_____
_____

Does patient have drug allergies? If yes, list all:

_____
_____
_____
_____

AUTHORIZATION

I have reviewed the information of 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 helpful 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 insurance submissions.

Dentist to release all information necessary to secure the payment of benefits. I understnad that I am financially responsible for all chargees whether or not paid.

Signature _____ Date _____

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