DENTAL HISTORY

Reason for visit? _____ Are you in dental discomfort today? _____

Former Dentist: _____ Address: _____ Phone: _____

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

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

- ❑ Bad Breath
- ❑ Bleeding Gums
- ❑ Clicking or popping Jaw
- ❑ Food collection between teeth
- ❑ Grinding or clenching teeth
- ❑ Loose teeth or broken fillings
- ❑ Periodontal treatment
- ❑ Sensitivity to cold
- ❑ Sensitivity to hot
- ❑ Sensitivity to sweets
- ❑ Sensitivity when biting
- ❑ 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, please 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? ❑ Y ❑ N

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

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

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 dentists.

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 payments of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that I shall have to pay any fees needed to collect debts which are not paid.

Signature: _____ Date: _____

Payment is due in full at time of treatment.