

Dental History

Reason for Today's Visit _____

Former Dentist Name _____ Phone () _____

Date of Last Dental Care _____ Date of Last Dental X-rays _____

Mark YES or NO if you have had problems with any of the following:

- | | | |
|--|---|--|
| <input type="checkbox"/> YES <input type="checkbox"/> NO Bad breath | <input type="checkbox"/> YES <input type="checkbox"/> NO Grinding teeth | <input type="checkbox"/> YES <input type="checkbox"/> NO Sensitive to hot |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Bleeding gums | <input type="checkbox"/> YES <input type="checkbox"/> NO Loose teeth or broken fillings | <input type="checkbox"/> YES <input type="checkbox"/> NO Sensitive to sweet |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Clicking or popping jaw | <input type="checkbox"/> YES <input type="checkbox"/> NO Periodontal treatment | <input type="checkbox"/> YES <input type="checkbox"/> NO Sensitivity when biting |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Food collection between teeth | <input type="checkbox"/> YES <input type="checkbox"/> NO Sensitive to cold | <input type="checkbox"/> YES <input type="checkbox"/> NO Sores or growths in mouth |

Medical History

Physician's Name _____ Date of Last Visit _____

Physician's Address _____ Phone () _____

Have you had any serious illnesses or operations? YES NO If yes, describe _____

Do you need to use antibiotics before any medical or dental treatment? YES NO If yes, describe _____

Women: Are you pregnant? YES NO Nursing? YES NO Taking birth control pills? YES NO

Mark YES or NO if you have or have had any of the following:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> YES <input type="checkbox"/> NO AIDS | <input type="checkbox"/> YES <input type="checkbox"/> NO Cough, Persistent | <input type="checkbox"/> YES <input type="checkbox"/> NO High Blood Pressure | <input type="checkbox"/> YES <input type="checkbox"/> NO Scarlet Fever |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Anemia | <input type="checkbox"/> YES <input type="checkbox"/> NO Cough up Blood | <input type="checkbox"/> YES <input type="checkbox"/> NO HIV Positive | <input type="checkbox"/> YES <input type="checkbox"/> NO Shortness of Breath |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Arthritis, Rheumatism | <input type="checkbox"/> YES <input type="checkbox"/> NO Diabetes | <input type="checkbox"/> YES <input type="checkbox"/> NO Jaw Pain | <input type="checkbox"/> YES <input type="checkbox"/> NO Skin Rash |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Artificial Heart Valves | <input type="checkbox"/> YES <input type="checkbox"/> NO Diet Medication | <input type="checkbox"/> YES <input type="checkbox"/> NO Kidney Disease | <input type="checkbox"/> YES <input type="checkbox"/> NO Stroke |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Artificial Joints | <input type="checkbox"/> YES <input type="checkbox"/> NO Epilepsy | <input type="checkbox"/> YES <input type="checkbox"/> NO Liver Disease | <input type="checkbox"/> YES <input type="checkbox"/> NO Swelling of Feet or Ankles |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Asthma | <input type="checkbox"/> YES <input type="checkbox"/> NO Fainting | <input type="checkbox"/> YES <input type="checkbox"/> NO Mitral Valve Prolapse | <input type="checkbox"/> YES <input type="checkbox"/> NO Thyroid Problems |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Back Problems | <input type="checkbox"/> YES <input type="checkbox"/> NO Glaucoma | <input type="checkbox"/> YES <input type="checkbox"/> NO Nervous Problems | <input type="checkbox"/> YES <input type="checkbox"/> NO Tobacco Habit |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Blood Disease | <input type="checkbox"/> YES <input type="checkbox"/> NO Headaches | <input type="checkbox"/> YES <input type="checkbox"/> NO Pacemaker | <input type="checkbox"/> YES <input type="checkbox"/> NO Tonsillitis |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Cancer | <input type="checkbox"/> YES <input type="checkbox"/> NO Heart Murmur | <input type="checkbox"/> YES <input type="checkbox"/> NO Phen-Fen Diet Plan | <input type="checkbox"/> YES <input type="checkbox"/> NO Tuberculosis |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Chemical Dependency | <input type="checkbox"/> YES <input type="checkbox"/> NO Heart Problems | <input type="checkbox"/> YES <input type="checkbox"/> NO Psychiatric Care | <input type="checkbox"/> YES <input type="checkbox"/> NO Ulcers |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Chemotherapy | Describe _____ | <input type="checkbox"/> YES <input type="checkbox"/> NO Radiation Treatment | <input type="checkbox"/> YES <input type="checkbox"/> NO Venereal Disease |
| <input type="checkbox"/> YES <input type="checkbox"/> NO Cortisone Treatments | <input type="checkbox"/> YES <input type="checkbox"/> NO Hepatitis | <input type="checkbox"/> YES <input type="checkbox"/> NO Rheumatic Fever | <input type="checkbox"/> YES <input type="checkbox"/> NO Allergy to LATEX |

MEDICATIONS

List all medications you are currently taking:

ALLERGIES

List all allergies you have:

Authorization

I declare that all information given are correct and true to the best of my knowledge. It is my responsibility to inform this office of any changes in my medical history and dental insurance status. I will not hold the dentist responsible for any omissions I have made in the completion of this form. I authorize the dentist to perform all dental services agreed upon between the dentist and myself or guardian. I understand the use of anesthetics and other medications may be necessary and may pose a certain risk.

I authorize my insurance company to pay to the dentist or dental group 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.

I understand that payment is due in full at time of treatment unless prior arrangements have been approved.

Signature of Patient or Guardian _____ Date _____