

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 had problems with any of the following:

- | | | | |
|---|--|---|---|
| ☐ Y ☐ N Bad breath | ☐ Y ☐ N Food collection between teeth | ☐ Y ☐ N Periodontal treatment | ☐ Y ☐ N Sensitivity to sweets |
| ☐ Y ☐ N Bleeding gums | ☐ Y ☐ N Grinding or clenching teeth | ☐ Y ☐ N Sensitivity to cold | ☐ Y ☐ N Sensitivity when biting |
| ☐ Y ☐ N Clicking or popping jaw | ☐ Y ☐ N Loose teeth or broken fillings | ☐ Y ☐ N Sensitivity to hot | ☐ 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 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 _____

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

Have you ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva. ☐ Y ☐ N

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

Check (✓) yes or no whether you have had any of the following:

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

Is patient currently taking any medications? If yes, list all:

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

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.