Dental History

Reason for today's visit? _____

Former Dentist _____ Address _____ Phone _____

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

Check if you have the following:

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

How often do you brush? _____ How often do you 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

Medical History

Physician's name _____ Address _____ 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 date(s) _____

Have you ever taken Fosomax/Redux? ☐Y ☐N

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

Check if you have had the following:

- ☐ AIDS/HIV Positive
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial heart valves
- ☐ Artificial joints
- ☐ Asthma
- ☐ Atopic (allergy prone)
- ☐ Back problems
- ☐ Blood disease
- ☐ Cancer
- ☐ Chemical dependency
- ☐ 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 fever
- ☐ 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 dentist.

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 authorize dental services/treatment for me and fully understand that during, and following treatment, conditions may become apparent which warrant, in judgement of the doctor, additional or alternative treatment pertinent to the success of comprehensive treatment.

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

Signature _____ Date _____