Dental History

What would you like us to do at your first visit? _____Are you in dental discomfort? _____

Former Dentist_____Address_____

Dentist's Email_____Phone_____

Date of last dental care_____Date of last x-rays_____

Check (✓) if you have had 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 to 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 illness 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

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

Check (✓) if you have or 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 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
- ❑ High blood pressure
- ❑ Jaw pain
- ❑ Kidney disease
- ❑ 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
- ❑ Swelling of feet or ankles
- ❑ Thyroid disease or malfunction
- ❑ Tobacco habit
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Ulcer/Colitis
- ❑ Venereal disease

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

_____

_____

Do you have any 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 the patient registration form to pay 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