

## 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:

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Bad breath              | <input type="checkbox"/> Y <input type="checkbox"/> N Food collection between teeth  | <input type="checkbox"/> Y <input type="checkbox"/> N Periodontal treatment | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to sweets     |
| <input type="checkbox"/> Y <input type="checkbox"/> N Bleeding gums           | <input type="checkbox"/> Y <input type="checkbox"/> N Grinding or clenching teeth    | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to cold   | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity when biting   |
| <input type="checkbox"/> Y <input type="checkbox"/> N Clicking or popping jaw | <input type="checkbox"/> Y <input type="checkbox"/> N Loose teeth or broken fillings | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to hot    | <input type="checkbox"/> Y <input type="checkbox"/> 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

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:

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