

Dental History

What would you like us to do today? _____ Are you in discomfort? _____

Former Dentist _____ Phone Number _____

Date of Last Dental Care _____ Date of last x-rays _____

Check (✓) yes or no if you have had any problems with any of the following:

- | | |
|---|--|
| Yes No | Yes No |
| <input type="checkbox"/> <input type="checkbox"/> Bad Breath | <input type="checkbox"/> <input type="checkbox"/> Bleeding Gums |
| <input type="checkbox"/> <input type="checkbox"/> Clicking or Popping Jaw | <input type="checkbox"/> <input type="checkbox"/> Food Collection between Teeth |
| <input type="checkbox"/> <input type="checkbox"/> Grinding or Clenching Teeth | <input type="checkbox"/> <input type="checkbox"/> Loose teeth or Broken Fillings |
| <input type="checkbox"/> <input type="checkbox"/> Periodontal Treatment | <input type="checkbox"/> <input type="checkbox"/> Sensitivity to cold |
| <input type="checkbox"/> <input type="checkbox"/> Sensitivity to hot | <input type="checkbox"/> <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> <input type="checkbox"/> Sensitivity when biting | <input type="checkbox"/> <input type="checkbox"/> Sores or growths in mouth |

How often do you brush _____ Floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever had an adverse reaction during or in conjunction with a medical or dental procedure? If yes, explain _____

Other information about your dental health or previous treatment _____

Medical History

Physicians Name _____ Phone _____

Date of last visit _____ Have you had any illnesses or operations? _____

If yes, describe _____

Are you currently under physician care? _____ If yes, describe _____

Have you ever taken Fen-Phen/Redux? _____

Women: Are you pregnant _____ Nursing? _____ Taking birth control pills? _____

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

- | | | | |
|--|---|--|--|
| Yes No | Yes No | Yes No | Yes No |
| <input type="checkbox"/> <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> <input type="checkbox"/> Cough, persistent | <input type="checkbox"/> <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> <input type="checkbox"/> Respiratory disease |
| <input type="checkbox"/> <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> <input type="checkbox"/> Cough up blood | <input type="checkbox"/> <input type="checkbox"/> Kidney disease | <input type="checkbox"/> <input type="checkbox"/> Rheumatic/ |
| <input type="checkbox"/> <input type="checkbox"/> Anemia | <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> or malfunction | <input type="checkbox"/> <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> <input type="checkbox"/> Epilepsy | <input type="checkbox"/> <input type="checkbox"/> Liver Disease | <input type="checkbox"/> <input type="checkbox"/> Shingles |
| <input type="checkbox"/> <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> <input type="checkbox"/> Fainting | <input type="checkbox"/> <input type="checkbox"/> Material Allergies | <input type="checkbox"/> <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> <input type="checkbox"/> Asthma | <input type="checkbox"/> <input type="checkbox"/> Food Allergies | <input type="checkbox"/> <input type="checkbox"/> (latex, wool, metal | <input type="checkbox"/> <input type="checkbox"/> Skin rash |
| <input type="checkbox"/> <input type="checkbox"/> Atopic (allergy prone) | <input type="checkbox"/> <input type="checkbox"/> Glaucoma | <input type="checkbox"/> <input type="checkbox"/> chemicals) | <input type="checkbox"/> <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> <input type="checkbox"/> Back Problems | <input type="checkbox"/> <input type="checkbox"/> Headaches | <input type="checkbox"/> <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> <input type="checkbox"/> Stroke |
| <input type="checkbox"/> <input type="checkbox"/> Blood disease | <input type="checkbox"/> <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> <input type="checkbox"/> Surgical Implant |
| <input type="checkbox"/> <input type="checkbox"/> Cancer | <input type="checkbox"/> <input type="checkbox"/> Heart Problems | <input type="checkbox"/> <input type="checkbox"/> Pacemaker/ | <input type="checkbox"/> <input type="checkbox"/> Swelling feet/ankles |
| <input type="checkbox"/> <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> <input type="checkbox"/> Describe: _____ | <input type="checkbox"/> <input type="checkbox"/> Heart surgery | <input type="checkbox"/> <input type="checkbox"/> Thyroid disease/ |
| <input type="checkbox"/> <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> <input type="checkbox"/> Hemophilia | <input type="checkbox"/> <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> <input type="checkbox"/> malfunction |
| <input type="checkbox"/> <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> <input type="checkbox"/> Herpes | <input type="checkbox"/> <input type="checkbox"/> Rapid weight gain/loss | <input type="checkbox"/> <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> <input type="checkbox"/> Cortisone treatments | <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Radiation treatment | <input type="checkbox"/> <input type="checkbox"/> Tonsillitis |
| | | | <input type="checkbox"/> <input type="checkbox"/> Venereal disease |

----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 _____

