

## Dental History

What would you like us to do today?

Are you in dental discomfort today?

Former Dentist

Dentist's email

Date of last dental care

Address

Phone

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

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	Y	N	Spina Bifida
Y	N	Artificial joints	Y	N	Mitral valve prolapse	Y	N	Surgical implant	Y	N	Stroke
Y	N	Food allergies	Y	N	Glaucoma	Y	N	Nervous problems	Y	N	Swelling of feet or ankles
Y	N	Asthma	Y	N	Headaches	Y	N	Pacemaker/Heart surgery	Y	N	Thyroid disease or malfunction
Y	N	Atopic (allergy prone)	Y	N	Heart murmur	Y	N	Psychiatric care	Y	N	Tobacco habit
Y	N	Back problems	Y	N	Heart problems	Y	N	Rapid weight gain or loss	Y	N	Tonsillitis
Y	N	Blood disease	Y	N	Hemophilia/Abnormal bleeding	Y	N	Radiation treatment	Y	N	Tuberculosis
Y	N	Cancer: Describe	Y	N	Herpes	Y	N	Respiratory disease	Y	N	Ulcer/Colitis
Y	N	Chemical dependency	Y	N	Hepatitis	Y	N	Rheumatic/Scarlet fever	Y	N	Venereal disease
Y	N	Chemotherapy	Y	N	High blood pressure	Y	N	Artificial heart valves			
Y	N	Circulatory problems	Y	N	Fainting						
Y	N	Cortisone treatments									

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.***