

## DENTAL HISTORY

Reason for today's visit \_\_\_\_\_ Date of last dental care \_\_\_\_\_

Former Dentist \_\_\_\_\_ Date of last dental X-rays \_\_\_\_\_

Address \_\_\_\_\_

Check ( ✓ ) if you have had problems with any of the following:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Bad breath                        | <input type="checkbox"/> Grinding teeth                 | <input type="checkbox"/> Sensitivity to hot             |
| <input type="checkbox"/> Bleeding gums                     | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets          |
| <input type="checkbox"/> Clicking or popping jaw           | <input type="checkbox"/> Periodontal treatment          | <input type="checkbox"/> Sensitivity when biting        |
| <input type="checkbox"/> Food collection between the teeth | <input type="checkbox"/> Sensitivity to cold            | <input type="checkbox"/> Sores or growths in your mouth |

How often do you floss? \_\_\_\_\_ How often do you brush? \_\_\_\_\_

## MEDICAL HISTORY

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva.  Yes  No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).  Yes  No

Have you had any serious illnesses or operations?  Yes  No If yes, describe \_\_\_\_\_

Have you ever had a blood transfusion?  Yes  No If yes, give approximate dates \_\_\_\_\_

(Women) Are you pregnant?  Yes  No Nursing?  Yes  No Taking birth control pills?  Yes  No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

- |                              |  |                              |   |                              |  |                              |   |
|------------------------------|--|------------------------------|---|------------------------------|--|------------------------------|---|
| Yes <input type="checkbox"/> | No <input type="checkbox"/>                            | Yes <input type="checkbox"/> | No <input type="checkbox"/>                       | Yes <input type="checkbox"/> | No <input type="checkbox"/>                    | Yes <input type="checkbox"/> | No <input type="checkbox"/>                         |
| <input type="checkbox"/>     | <input type="checkbox"/> Anemia                        | <input type="checkbox"/>     | <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/>     | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/>     | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/>     | <input type="checkbox"/> Arthritis, Rheumatism         | <input type="checkbox"/>     | <input type="checkbox"/> Cortisone Treatments     | <input type="checkbox"/>     | <input type="checkbox"/> Hernia Repair         | <input type="checkbox"/>     | <input type="checkbox"/> Shortness of Breath        |
| <input type="checkbox"/>     | <input type="checkbox"/> Artificial Heart Valves       | <input type="checkbox"/>     | <input type="checkbox"/> Cough, Persistent        | <input type="checkbox"/>     | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/>     | <input type="checkbox"/> Skin Rash                  |
| <input type="checkbox"/>     | <input type="checkbox"/> Artificial Joints, Pins, etc. | <input type="checkbox"/>     | <input type="checkbox"/> Cough up Blood           | <input type="checkbox"/>     | <input type="checkbox"/> HIV/AIDS              | <input type="checkbox"/>     | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/>     | <input type="checkbox"/> Asthma                        | <input type="checkbox"/>     | <input type="checkbox"/> Diabetes                 | <input type="checkbox"/>     | <input type="checkbox"/> Jaw Pain              | <input type="checkbox"/>     | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/>     | <input type="checkbox"/> Back Problems                 | <input type="checkbox"/>     | <input type="checkbox"/> Epilepsy                 | <input type="checkbox"/>     | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/>     | <input type="checkbox"/> Thyroid Problems           |
| <input type="checkbox"/>     | <input type="checkbox"/> Bleeding Abnormally           | <input type="checkbox"/>     | <input type="checkbox"/> Fainting                 | <input type="checkbox"/>     | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/>     | <input type="checkbox"/> Tobacco Habit              |
| <input type="checkbox"/>     | <input type="checkbox"/> Blood Disease                 | <input type="checkbox"/>     | <input type="checkbox"/> Glaucoma                 | <input type="checkbox"/>     | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/>     | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/>     | <input type="checkbox"/> Cancer                        | <input type="checkbox"/>     | <input type="checkbox"/> Headaches                | <input type="checkbox"/>     | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/>     | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/>     | <input type="checkbox"/> Chemical Dependency           | <input type="checkbox"/>     | <input type="checkbox"/> Heart Murmur             | <input type="checkbox"/>     | <input type="checkbox"/> Radiation Treatment   | <input type="checkbox"/>     | <input type="checkbox"/> Ulcer                      |
| <input type="checkbox"/>     | <input type="checkbox"/> Chemotherapy                  | <input type="checkbox"/>     | <input type="checkbox"/> Heart Problems           | <input type="checkbox"/>     | <input type="checkbox"/> Respiratory Disease   | <input type="checkbox"/>     | <input type="checkbox"/> Venereal Disease           |
| <input type="checkbox"/>     | <input type="checkbox"/> Circulatory Problems          | <input type="checkbox"/>     | <input type="checkbox"/> Hemophilia               | <input type="checkbox"/>     | <input type="checkbox"/> Rheumatic Fever       |                              |   |

List medications you are currently taking and the correlating diagnosis:

Allergies:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to  
Name of Insurance Company(ies)

Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Relationship to Patient

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