

Patient Name: _____

Dental History

What would you like us to do today? _____

Are you in dental discomfort today? _____

Former Dentist _____ Phone # _____

Date of last dental care _____ Date of last x-rays _____

Circle Y/N if you have had any of the following:

- | | | | |
|-----|-------------------------------|-----|--------------------------------|
| Y/N | Bad Breath | Y/N | Sensitivity to cold /Hot |
| Y/N | Food collection between teeth | Y/N | Sensitivity when biting |
| Y/N | Periodontal treatment | Y/N | Clicking or popping jaw |
| Y/N | Sensitivity to sweets | Y/N | Loose teeth or broken fillings |
| Y/N | Bleeding gums | Y/N | Sores or growth in mouth |
| Y/N | Grinding or clenching teeth | | |

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 If yes, explain _____

Other information about your dental health or previous treatment _____

Medical History

Physician's Name _____ Phone # _____

Date of last visit _____

Have you ever 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 been required to take antibiotics before a dental appointment? Y/N

Have you ever had a blood transfusion? Y/N If yes, give approx. dates _____

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

Circle Y/N whether you have had any of the following:

- | | | | | | |
|-----|-------------------------|-----|-----------------------------------|-----|----------------------------|
| Y/N | AIDS/HIV Positive | Y/N | Headaches | Y/N | Radiation Treatment |
| Y/N | Anaphylaxis | Y/N | Heart Murmur | Y/N | Respiratory Disease |
| Y/N | Anemia | Y/N | Heart Problems | Y/N | Rheumatic/Scarlet
Fever |
| Y/N | Arthritis, Rheumatism | Y/N | Hemophilia/Abnormal Bleeding | Y/N | Shortness of Breath |
| Y/N | Artificial Heart Valves | Y/N | Herpes | Y/N | Spina Bifida |
| Y/N | Artificial Joints | Y/N | Hepatitis | Y/N | Stroke |
| Y/N | Asthma | Y/N | High Blood Pressure | Y/N | Surgical Implant |
| Y/N | Back Problems | Y/N | Jaw Pain | Y/N | Thyroid Disease |
| Y/N | Blood Disease | Y/N | Kidney Disease or Malfunction | Y/N | Hyper/Hypo |
| Y/N | Cancer | Y/N | Rapid Weight Gain/Loss | Y/N | Seizure |
| Y/N | Liver Disease | Y/N | Tobacco Habit | Y/N | Tuberculosis |
| Y/N | Chemotherapy | Y/N | Material Allergies (Latex, Metal) | Y/N | Ulcer/Colitis |
| Y/N | Circulatory Problems | Y/N | Mitral Valve Prolapse | Y/N | Venereal Disease |
| Y/N | Cortisone Treatments | Y/N | Nervous Problems | Y/N | Glaucoma |
| Y/N | Diabetes | Y/N | Pacemaker | Y/N | Heart Surgery |
| Y/N | Epilepsy | Y/N | Psychiatric Care | | |

Is patient currently taking any medications? Y/N If yes, please list all:

Does patient have any drug allergies? Y/N If yes, please list all:

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 first page of these forms 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 _____