DENTAL HISTORY

Name_____ Age_____

What do you prefer to be called? _____

Former Dentist _____ Why did you leave? _____

Reason for today's visit _____

Date of last exam _____ Date of last dental X-rays _____

How often do you brush? _____ How often do you floss _____

Please check any of the following conditions that apply to you:

__ Bad breath
___ Bleeding gums
___ Clicking or popping jaw
___ Food collection between teeth
____ Grinding teeth
____ Loose teeth or broken fillings
____ Periodontal treatment
____ Sores or growths in your mouth
_____Sensitivity to hot
_____ Sensitivity to sweets
_____ Sensitivity when biting
_____ Sensitivity to cold

Are you Happy with your smile? _____ yes _____no

What would you do to change it? _____

Medical History

Physician_____ Date of last visit _____

Please list all medications you are currently taking:

_____

_____

Allergies: _____

(Women) Are you pregnant? ____ yes ____ no Nursing? ___yes ___no Taking birth control pills? __yes ___ no

Do you have a history of the following?

__AIDS
__Anemia
__Arthritis, Rheumatism
__Artificial Heart Valves
__Artificial Joints
__Asthma
__Back Problems
__Blood Disease
__Cancer
__Chemical Dependency
__Chemotherapy
__Circulatory Problems
__Cortisone Treatments
__Cough, Persistent
__Cough up Blood
__Diabetes
__Epilepsy
__Fainting
__Glaucoma
__Headaches
__Heart Murmur
__Heart Problems
Describe_____
__Hemophilia
__Hepatitis
__High Blood Pressure
__HIV Positive
__Jaw Pain
__Kidney Disease
__Liver Disease
__Metal Allergies
__Mitral Valve Prolapse
__Nervous Problems
__Pacemaker
__Psychiatric Care
__Radiation Treatment
__Respiratory Disease
__Rheumatic Fever
__Scarlet Fever
__Shortness of Breath
__Skin Rash
__Stroke
__Swelling of feet/ankles
__Thyroid Problems
__Tobacco Habit
__Tonsillitis
__Tuberculosis
__Ulcer
__Venereal Disease

Authorization

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____

SIGNATURE OF PATIENT (Or parent if a minor) **DATE**