Dental Health History

What bring you in today? ____

Date of last dental visit? ____________________________________

Are you experiencing dental pain or discomfort? ❑ Yes ❑ No

Do you have dental anxiety? ❑ Yes ❑ No

Have you had problems with previous dental treatment? ❑ Yes ❑ No

Are your teeth sensitive? ❑ Yes ❑ No

Do you feel twinges of pain when you brush or floss? ❑ Yes ❑ No

Do your gums feel swollen or tender? ❑ Yes ❑ No

Do you have difficulty chewing your food? ❑ Yes ❑ No

Do you have any missing teeth? ❑ Yes ❑ No

Do you wear dentures? ❑ Yes ❑ No

Have your wisdom teeth been removed? ❑ Yes ❑ No

Do you clench or grind your jaws frequently? ❑ Yes ❑ No

Do you have any jaw symptoms or headaches upon waking in the morning? ❑ Yes ❑ No

Have you ever had trauma to your jaw?

Medical Health History

Are you in good health? ❑ Yes ❑ No

Has there been a change in your general health within the past year? ❑ Yes ❑ No

Do you smoke or use tobacco products? ❑ Yes ❑ No

Are you under the care of a physician? ❑ Yes ❑ No

If so, what condition is being treated? ____

Physicians Name: ________________________ Phone Number: _______________________________

Women: Are you pregnant or think you might be? ❑ Yes ❑ No

Expected delivery date: __________________ Are you nursing? ❑ Yes ❑ No

OBGYN Name: ________________________ Phone Number: __________________________

PLEASE CHECK ANY OF THE FOLLOWING THAT APPLY:

- ❑AIDS
- ❑ ALCOHOLISM
- ❑ ANEMIA
- ❑ ANGINA
- ❑ ARTIFICIAL HEART VALVE
- ❑ ARTIFICIAL JOINTS
- ❑ ARTHRITIS/RHEUMATISM
- ❑ ASTHMA
- ❑ BIRTH CONTROL
- ❑ BLOOD PRESSURE-HIGH
- ❑ BLOOD PRESSURE-LOW
- ❑ BLOOD THINNERS
- ❑ BRUISE BASILY
- ❑ CANCER
- ❑ CHEMOTHERAPY/RADIATION
- ❑ CONGENITAL HEART DISEASE
- ❑ DEAF
- ❑ DIABETES
- ❑DRUG DEPENDENCY
- ❑EATING DISORDER
- ❑ EMPHYSEMA
- ❑ EPILEPSY/SEIZURES
- ❑ FAINTING/DIZZY SPELLS
- ❑ FEVER BLISTER
- ❑ GAG EASILY
- ❑ GLAUCOMA
- ❑ HEADACHES-FREQUENT
- ❑ HEART ATTACK
- ❑ HEART MURMUR
- ❑ HEMOPHILIA
- ❑ HEPATITIS
- ❑ HEREDITARY DISEASE
- ❑ HIV POSITIVE
- ❑HERPES
- ❑ HYPERACTIVITY
- ❑ HYPOGLYCEMIA
- ❑ JAUNDICE
- ❑ KIDNEY/LIVER DISEASE
- ❑ MITRAL VALVE PROLAPSE
- ❑ NIGHT SWEATS
- ❑ OSTEOPOROSIS
- ❑ PARALYSIS
- ❑ PROLONGED BLEEDING
- ❑ PSYCHIATRIC TREATMENT
- ❑ RHEUMATIC FEVER
- ❑ SICKLE CELL DISEASE
- ❑ SINUS TROUBLE.
- ❑ STROKE
- ❑ TUBERCULOSIS
- ❑ TUMORS
- ❑ VENEREAL DISEASE

Have you had any other serious illness? ❑ Yes ❑ No (Please describe in detail) ________________________
____

Medications

Please list any medication you are taking now: ____
Reason: ____
Have you taken any medication for the last 6 months? ❑ Yes ❑ No (Please list) ________________________
____
Are you allergic to or have you had a bad reaction to:

- ❑ASPRIN
- ❑BARBITURATES
- ❑CODEINE
- ❑ERYTHROMYCIN
- ❑KEFLEX
- ❑LOCAL ANESTHETIC
- ❑NITROUS OXIDE
- ❑NARCOTICS
- ❑PENICLLIN
- ❑SULFA
- ❑TETRACYCLINE
- ❑LATEX

❑OTHER (ALLERGIES/DESCRIBE) ____

CONSENT: As the undersigned, 1 hereby authorize Doctor to, after thorot.gb explanation, take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a diagnosis of my dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated (after they are discussed with me) and further authorize and consent that Doctor choose and employ such assistance as he/she deems fit. I also understand the use of anesthetic agents embodies a certain risk. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform this dental office of any changes in medical status.

I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due, and payable at the time services are rendered.
All proceeds of insurance are assigned to the Doctor when applicable, but without the doctor assuming responsibility for the collection of those claims. If the insurance company does not pay my claim within 60 days after it is sent, it is understood that I pay the balance of my account end that I contact my insurance company regarding settlement. It is agreed that payment will not be delayed or withheld because of pending insurance coverage.

Signature of Patient, Parent or Guardian: _________________________________ Date: ___________________