

DENTAL HISTORY

Reason for today's visit _____ Date: last dental care _____ X-Rays _____

Former Dentist _____ Reason for Leaving Previous Dentist _____

What Changes Would You Like For Your Smile? _____

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

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Piercing | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Food collecting between the teeth | <input type="checkbox"/> Previous Dental Treatment | <input type="checkbox"/> Sores or growths in your mouth | <input type="checkbox"/> Sensitivity to cold |

How often do you floss _____ How often do you brush? _____ Use Oral Irrigation? Yes No

MEDICAL HISTORY

Physician's Name _____ Date last visit _____ Telephone # _____

Have you been tested for HIV? Yes No If yes, when? _____ Positive Negative

Have you been tested for Hepatitis? Yes No If yes, when _____ Positive Negative

Have you had the Hepatitis Vaccine? Yes No If yes, when _____

Have you ever 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 _____

Have you ever taken any of the group of drugs collectively referred to as 'Fen-Phen'? Yes No _____

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

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

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Joints, Pins, etc. | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Cough up Blood | <input type="checkbox"/> Sinus | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Bleeding Abnormally | <input type="checkbox"/> Fainting | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Psychiatric |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Headaches | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Chemical Dependency <input type="checkbox"/> Drug <input type="checkbox"/> Alcohol | <input type="checkbox"/> Tobacco Habit <input type="checkbox"/> Smoke <input type="checkbox"/> Chew <input type="checkbox"/> Smokless | <input type="checkbox"/> Respiratory Disease | <input type="checkbox"/> Venereal Disease |
| | | | <input type="checkbox"/> Seizure Disorder |

List medications you are currently taking:

Allergies:

- | | | | |
|--|---|---------------------------------|--------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Iodine | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Barbiturates (Sleeping Pills) | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Latex | |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Sulfa | <input type="checkbox"/> None | |

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 or health status.

Signature of 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.