Dental History

Name_____

Former Dentist_____ Date of last exam_____ Date of last x-rays_____

Reason for today's visit _____

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

How do you feel about the appearance of your teeth?_____

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

- ❑ Bad breath
- ❑ Bleeding gums
- ❑ Clicking or popping jaw
- ❑ Food collection between teeth
- ❑ Grinding of teeth
- ❑ Loose teeth or broken fillings
- ❑ Periodontal treatment
- ❑ Sores or growths in mouth
- ❑ Sensitivity to hot
- ❑ Sensitivity to sweets
- ❑ Sensitivity when chewing
- ❑ Sensitivity to cold

OFFICE USE ONLY

Medical History

Physician's Name_____ Date of last visit_____

Women: Are you pregnant or nursing? _____ Are you taking birth control? _____

Please list all medications you are taking, amounts and how often: _____

_____

Please list any allergies:_____

*** Do you need to pre-medicate before dental procedures due to a heart murmur or joint replacement?**_____

Please check any of the following that apply to you:

- ❑ AIDS
- ❑ Anemia
- ❑ Arthritis, Rheumatism
- ❑ 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
- ❑ Hemophilia
- ❑ Hepatitis
- ❑ High blood pressure
- ❑ HIV positive
- ❑ Jaw pain
- ❑ Kidney disease
- ❑ Liver disease
- ❑ Mitral valve prolapse
- ❑ Nervous problems
- ❑ Pacemaker
- ❑ Psychiatric care
- ❑ Radiation treatment
- ❑ Respiratory disease
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Skin rash
- ❑ Stroke
- ❑ Swelling of feet/ankles
- ❑ Thyroid problems
- ❑ Tobacco habit
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ 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 my 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.

_____

Signature of patient (or parent or legal guardian if a minor) Date Reviewed by Doctor

MEDICAL UPDATES

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past and present conditions.

Date	Exceptions	Patient's Signature	Reviewed by
_____	_____	_____	DR. _____
_____	_____	_____	DR. _____
_____	_____	_____	DR. _____
_____	_____	_____	DR. _____
_____	_____	_____	DR. _____