Dental & Medical History

Date of your last dental visit? _____ What would you like us to do today? _____
Are you having any discomfort at this time? ❑YES ❑NO Does dental treatment make you nervous? ❑No ❑Slightly ❑Moderately ❑Extremely
Do you brush ❑YES ❑NO How often do you brush? _____ Brush is: ❑Soft ❑Medium ❑Hard
Do you use the following? Dental Floss ❑YES ❑NO Fluoride Rinse ❑YES ❑NO, Other _____
Have you ever been treated for any type of gum problems? ❑YES ❑NO
How would you rate your dental health? ❑Excellent ❑Good ❑Poor
Are you happy with the appearance of your teeth? ❑YES ❑NO *If no, what would you change?*_____

DO YOU HAVE ANY OF THE FOLLOWING? ❑YES ❑NO Bleeding/sore gums ❑YES ❑NO Bad Breath.
❑YES ❑NO Food stuck in teeth ❑YES ❑NO Loose teeth ❑YES ❑NO Shifting in bite ❑YES ❑NO Clenching/grinding
❑YES ❑NO Sensitive to cold ❑YES ❑NO Sensitive to hot ❑YES ❑NO Sensitive to sweet ❑YES ❑NO Headaches
❑YES ❑NO Clicking/popping jaw ❑YES ❑NO Sensitive to biting ❑YES ❑NO Biting cheeks/lips ❑YES ❑NO Ortho/Braces

Is patient currently taking any medications? List all:
_____
_____

Does patient have any drug allergies? List all:
_____
_____

Have you ever used a bisphosphonate medication? (Fosamax, Actonel, Atelvia, Didronel and Boniva) ❑YES ❑NO
Have you ever taken Fen-Phen/Redux? ❑YES ❑NO

WOMEN: Are you pregnant ❑YES ❑NO Nursing ❑YES ❑NO Taking birth control ❑YES ❑NO

ANY HISTORY OF: (please mark yes or no)

❑YES ❑NO Anemia ❑YES ❑NO Arthritis/Rheumatism ❑YES ❑NO Artificial Joints ❑YES ❑NO Tested Positive for HIV /AIDS
❑YES ❑NO Asthma ❑YES ❑NO Allergies ❑YES ❑NO Back Problems ❑YES ❑NO Artificial Heart Valves
❑YES ❑NO Blood Disease ❑YES ❑NO Bronchitis Cancer ❑YES ❑NO Blood Transfusions ❑YES ❑NO Chemical Dependency
❑YES ❑NO Chemotherapy ❑YES ❑NO Cough, Persistent ❑YES ❑NO Cortisone or ACT II ❑YES ❑NO Circulatory Problems
❑YES ❑NO Diabetes ❑YES ❑NO Epilepsy/Convulsions ❑YES ❑NO Fainting/Dizzy Spells ❑YES ❑NO Fever Blisters/Herpes
❑YES ❑NO Glaucoma. ❑YES ❑NO Headaches ❑YES ❑NO Heart Murmur ❑YES ❑NO Heart Problems
❑YES ❑ NO Hepatitis ❑YES ❑NO Herpes ❑YES ❑NO Heart Valve Problem ❑YES ❑NO Hemophilia/Abnormal Bleeding
❑YES ❑NO High Blood Pressure ❑YES ❑NO Jaw Pain ❑YES ❑NO Lung Disease ❑YES ❑NO Kidney or Liver Disease
❑YES ❑NO Nervous Problems ❑YES ❑NO Nose Obstruction ❑YES ❑NO Psychiatric Care ❑YES ❑NO Mitral Valve Prolapse
❑YES ❑NO Shingles ❑YES ❑NO Radiation Treatment ❑YES ❑NO Rapid Weight gain/loss ❑YES ❑NO Pacemaker/Heart Surgery
❑YES ❑NO Shortness of Breath ❑YES ❑NO Rheumatic Fever ❑YES ❑NO Respiratory Disease ❑YES ❑NO Sinus Trouble
❑YES ❑NO Skin Rash ❑YES ❑NO Stroke ❑YES ❑NO Surgical Implant ❑YES ❑NO Tobacco Habit
❑YES ❑NO Thyroid Problems ❑YES ❑ NO Tonsillitis ❑YES ❑NO Swelling of Feet or ankles ❑YES ❑NO Tuberculosis
❑YES ❑NO Ulcers/Colitis

CONSENT

I have answered all questions to the best of my knowledge. If further information is needed, you have my permission to ask my respective health care provider or agency who may release such information to you. I will notify this office of any changes in my health or medication. The undersigned hereby authorizes this office to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. Upon such diagnosis, I authorize this office to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I understand that using anesthetic agents embodies a certain risk. 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 unless financial arrangements have been made. All diagnostic aids and documentation are the property of this office. Original records may not be taken by the patient. All records are strictly confidential. Signing this form authorizes us to transfer records to another dentist. I have reviewed a copy of this office's Notice of Privacy Practices and I have been notified that I may have a copy.

Patient _____ Date _____ Witness _____
Parent or Responsible Party _____ Relationship to Patient _____