DENTAL HISTORY

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

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

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

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

MEDICAL HISTORY

Primary Physician's Name and Contact _____ Date of Last Visit _____

Have you 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?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

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

Do you have latex allergies? ☐ Yes ☐ No Have you ever used Bisphosphonate? ☐ Yes ☐ No

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

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Anemia	☐	☐	Cortisone Treatments	☐	☐	Hepatitis	☐	☐	Scarlet Fever
☐	☐	Arthritis, Rheumatism	☐	☐	Cough, Persistent	☐	☐	High Blood Pressure	☐	☐	Shortness of Breath
☐	☐	Artificial Heart Valves	☐	☐	Cough up Blood	☐	☐	HIV/AIDS	☐	☐	Skin Rash
☐	☐	Artificial Joints	☐	☐	Diabetes	☐	☐	Jaw Pain	☐	☐	Stroke
☐	☐	Asthma	☐	☐	Epilepsy	☐	☐	Kidney Disease	☐	☐	Swelling of Feet or Ankles
☐	☐	Back Problems	☐	☐	Fainting	☐	☐	Latex Allergy	☐	☐	Thyroid Problems
☐	☐	Blood Disease	☐	☐	Glaucoma	☐	☐	Liver Disease	☐	☐	Tobacco Habit
☐	☐	Cancer	☐	☐	Headaches	☐	☐	Mitral Valve Prolapse	☐	☐	Tonsillitis
☐	☐	Chemical Dependency	☐	☐	Heart Murmur	☐	☐	Pacemaker	☐	☐	Tuberculosis
☐	☐	Chemotherapy	☐	☐	Heart Problems	☐	☐	Radiation Treatment	☐	☐	Ulcer
☐	☐	Circulatory Problems	☐	☐	Hemophilia	☐	☐	Respiratory Disease	☐	☐	Venereal Disease
						☐	☐	Rheumatic Fever			

MEDICATIONS

List medications you are currently taking:

_____

_____

ALLERGIES

_____

_____

AUTHORIZATION

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature 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.