Dental History

(PLEASE FILL THIS FORM OUT COMPLETELY BOTH FRONT AND BACK, THANK YOU!)

Reason for today's visit ______________________________
Former Dentist ______________________________ Date of Last X-rays ______________
How often do you floss? ______________________ How often do you brush? ______________________

Please place a check beside any of the following that applies to you:

_____ Bad Breath
_____ Bleeding Gums
_____ Clicking/popping jaw
_____ Food collection between teeth
_____ Grinding teeth
_____ Loose teeth
_____ Broken Fillings
_____ Periodontal treatment
_____ Sensitive to hot/cold
_____ Other

If you checked Other, please explain: ______________________________

Medical History

Physician's Name ______________________________ Phone number ______________________
Have you had any serious illnesses/operations/injuries? ______________________
If Yes, please describe:

____

____

Have you ever had a blood transfusion? ______________ If yes, when? ______________________

For women only: Are you currently taking birth control pills? ______________ Are you pregnant? ______________
If Yes, how many weeks? ______________ Are you currently nursing? ______________

PLEASE INDICATE YES OR NO BESIDE EACH MEDICAL CONDITION. ALL CONDITIONS MUST BE MARKEDWITH AN ANSWER:

Y	N	Anemia	Y	N	Back Problems	Y	N	Difficulty Breathing	Y	N	Frequent Cough
Y	N	Artificial Heart Valve	Y	N	Chemotherapy	Y	N	Circulatory Problems	Y	N	Fainting/Dizzy Spells
Y	N	History of Substance Abuse	Y	N	Diabetes	Y	N	Epilepsy	Y	N	Hepatitis A, B, or C
Y	N	Cortisone Treatments	Y	N	Frequent Headaches	Y	N	Heart Murmur	Y	N	HIV/AIDS
Y	N	Glaucoma	Y	N	Heart Problems	Y	N	High Blood Pressure	Y	N	Pacemaker
Y	N	Heart Attack	Y	N	Liver Disease	Y	N	Mitral Valve Prolapse	Y	N	Stroke
Y	N	Kidney Disease	Y	N	Respiratory Disease	Y	N	Rheumatic Fever	Y	N	Taken Phen-Phen or Redux
Y	N	Radiation treatment	Y	N	Venereal Disease	Y	N	Jaw Pain	Y	N	Low Blood Pressure
Y	N	Thyroid problems	Y	N	Artificial joints/pins	Y	N	Asthma	Y	N	Heavy Bleeding
Y	N	Arthritis	Y	N	Blood Disease	Y	N	Cancer	Y	N	Head or Neck injury

Please list any other condition not listed above that we should be aware of:

____

____

List ALL medications you are currently taking:

____

____

PLEASE TURN OVER AND CONTINUE FILLING OUT FORM

Are you ALLERGIC to any of the following? PLEASE MARK YES OR NO TO ALL ALLERGY INQUIRIES

Y	N	Penicillin	Y	N	Amoxicillin	Y	N	Codeine	Y	N	Sulfa
Y	N	Metals	Y	N	Latex	Y	N	Ibuprofen	Y	N	Other

If Other, please list: ____

AUTHORIZATION

I authorize my insurance company to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to seek payment of benefits. I understand there will be a $40 charge for any missed appointments with less than 24 hours notice of cancellation. I understand that I am financially responsible for all charges not paid by my insurance company. I understand that payment is due at time of service on all dental procedures.

Signature ______________________________ Date______________________
(Patient's signature/Guardian's signature)