

Dental History

Name _____ DOB _____

Former Dentist _____

Reason for today's visit _____

Date of last exam _____ Date of last dental X-rays _____

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

Are you happy with your smile? Yes or No Have you used Botox or fillers before?

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

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores or growths in your mouth |
| | | <input type="checkbox"/> Dental anxiety |

Medical History

Physician _____ Date of last visit _____

Please list all medications you are currently taking: _____

Allergies: _____

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

Do you have a history of the following?

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cough up blood | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> Headaches | <input type="checkbox"/> Narcotic Use | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Nervous Disorder | Describe: _____ |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemotherapy | Describe _____ | <input type="checkbox"/> Premedication Required | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Venereal Disease |
| | | <input type="checkbox"/> Soda Consumption | <input type="checkbox"/> Other Medical Concern Not Listed |
- Sources per day _____



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 any 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.

X _____

SIGNATURE OF PATIENT (Or parent if a minor)

DATE

CONFIDENTIAL