

## Dental History

What would you like us to do today?				Are you	Are you in dental discomfort today?			
Former Dentist Address								
Dentist's Email Phone								
Date of last dental care Date of last x-rays								
Check ( ✓ ) yes or no if you have had problems with any of the following:								
$\square$ Y $\square$ N Bad breath $\square$ Y $\square$ N Food collection between teeth $\square$ Y $\square$ N Periodontal treatment $\square$ Y $\square$ N Sensitivity to sweets								
	1 Y □ N Bleeding gums □ Y □ N Grinding or clenching teeth			$\Box$ Y $\Box$ N	☐ Y ☐ N Sensitivity to cold ☐ Y ☐ N Sensitivity when biting		0.50	
☐ Y ☐ N Clicking or popping jaw ☐ Y ☐ N Loose teeth or broken filling					Sensitivity to hot	y to hot Y N Sores or growths in mouth		
How often do you brush?				Floss? .	Floss?			
How do you feel about the appearance of your teeth?								
Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? □ Y □ N								
Other information about your dental health or previous treatment								
Medical History								
Physician's namePhone								
Date of last visit Have you had any serious illnesses or operations? $\square Y \square N$								
If yes, describe								
Are you currently under physician care? $\square$ Y $\square$ N If yes, describe								
Have you ever had a blood transfusion? □ Y □ N If yes, give approximate dates								
Have you ever taken Fen-Phen/Redux? $\Box$ Y $\Box$ N								
Have you ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva. 🖂 Y 🖂 N								
Women: Are you pregnant? $\square$ Y $\square$ N Nursing? $\square$ Y $\square$ N Taking birth control pills? $\square$ Y $\square$ N								
Check ( ✓ ) yes or no whether you have had any of the following:								
$\square$ Y $\square$ N	AIDS/HIV Positive		Cough, persistent	$\square Y \square N$		$\square$ Y $\square$ N		
	Anaphylaxis		Cough up blood	$\Box$ Y $\Box$ N	Kidney disease or malfunction		Shortness of breath	
				ПУПИ	Liver disease			
	Arthritis, Rheumatism						Spina Bifida	
	Artificial heart valves			ar an	(latex, wool, metal,			
	Artificial joints		Food allergies		chemicals)		Surgical implant	
					Mitral valve prolapse	UYUN	Swelling of feet or ankles	
	Atopic (allergy prone)		Headaches	$\Box$ Y $\Box$ N	Nervous problems	$\Box v \Box v$	Thyroid disease or	
	Back problems		Heart murmur	$\square Y \square N$	Pacemaker/	<b>313</b> 1	malfunction	
	Blood disease	Describe	Heart problems		Heart surgery	$\Box$ Y $\Box$ N	Tobacco habit	
			Hemophilia/		Psychiatric care	$\Box$ Y $\Box$ N	Tonsillitis	
	Chemical dependency		Abnormal bleeding		Rapid weight gain or loss		Tuberculosis	
	Chemotherapy	$\square$ Y $\square$ N	1000		Radiation treatment	$\square$ Y $\square$ N	Ulcer/Colitis	
	Circulatory problems Cortisone treatments	$\square$ Y $\square$ N	R		Respiratory disease Rheumatic/Scarlet fever	$\square$ Y $\square$ N	Venereal disease	
			High blood pressure					
Is patient currently taking any medications? If yes, list all:  Does patient have drug allergies? If yes, list all:								
				-				
			Autho	orization				
I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.								
I authorize the insurance company indicated on this form to pay to 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 secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.								
Signature Date								
Payment is due in full at time of treatment, unless prior arrangements have been approved								