DENTAL HISTORY

Why have you come to the dentist today? ____________________

Are you currently in pain? ❑ Yes ❑ No

Do you require antibiotics before dental treatment? ❑ Yes ❑ No

Have you experienced problems associated with any previous dental work? ❑ Yes ❑ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ❑ Yes ❑ No

Your current dental health is ❑ Good ❑ Fair ❑ Poor

Do you floss daily? ❑ Yes ❑ No Brush daily? ❑ Yes ❑ No

Type of bristles on your toothbrush? ❑ Hard ❑ Medium ❑ Soft

How long do you use a toothbrush before replacing it? ____________________

Do you use anything in addition to your brush and floss? ❑ Yes ❑ No

If yes, what? ____________________

Would you like fresher breath? ❑ Yes ❑ No Whiter teeth? ❑ Yes ❑ No

Do your gums ever bleed? ❑ Yes ❑ No Ever Itch? ❑ Yes ❑ No

Have you ever had periodontal disease? ❑ Yes ❑ No

Do you have mobility in your teeth? ❑ Yes ❑ No

Are your teeth sensitive to heat, cold, or anything else? ____________________

Do you still have wisdom teeth? ❑ Yes ❑ No

If yes, why? ____________________

Previous / Present Dentist: ____________________ Last Visit Date: __________
(Please Circle)

Why did you leave your previous dentist? ____________________

What did you like most & least about any dentist you have seen? ____________________

Are you happy with the way your smile looks? ❑ Yes ❑ No

If not, what would you change? ____________________

MEDICAL HISTORY

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name: ____________________

Address: ____________________
Street City State Zip

Phone #: (____) __________ Date of last visit: __________

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No

Please explain: ____________________

Do you smoke or use tobacco in any other form? ❑ Yes ❑ No

Are you allergic to any of the following?

Y N Aspirin
Y N Barbiturates
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Jewelry / Metals
Y N Latex
Y N Penicillin
Y N Sedatives
Y N Sulfa Drugs
Y N Tetracycline
Y N Other

Please list additional drugs/materials that cause allergic reactions: ____________________

For Women: Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Unsure ❑ Yes ❑ No

Week #: __________ Are you nursing? ❑ Yes ❑ No

Are you taking any of the following?

Y N Acetaminophen
Y N Antibiotics
Y N Antihistamines
Y N Aspirin
Y N Blood Thinners
Y N Blood Pressure Medication
Y N Cold Remedies
Y N Digitalis/Heart Medication
Y N Insulin/Diabetes Drugs
Y N Nitroglycerin
Y N Recreational Drugs
Y N Steroids/Cortisone
Y N Thyroid Medicine
Y N Tranquilizers

Have you ever taken Phen-Fen? Also known as Redux or Pondimin. ❑ Yes ❑ No

Are you taking any prescription, over-the-counter drugs, herbal remedies, vitamins or minerals not listed above? ❑ Yes ❑ No If yes, please list each one: ____________________

Do you or have you experienced the following?

Y N Abnormal Bleeding
Y N Alcohol Abuse
Y N Anemia
Y N Arthritis
Y N Artificial Bones/Joints
Y N Artificial Valves
Y N Asthma
Y N Blood Transfusion
Y N Cancer
Y N Chemotherapy
Y N Chicken Pox
Y N Colitis
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Drug Abuse
Y N Emphysema
Y N Epilepsy
Y N Fainting Spells
Y N Fever Blisters
Y N Glaucoma
Y N Hay Fever
Y N Headaches
Y N Heart Attack
Y N Heart Murmur
Y N Heart Surgery
Y N Hemophilia
Y N Hepatitis
Y N Herpes
Y N High Blood Pressure
Y N HIV+/AIDS
Y N Hospitalized for Any Reason
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Pressure
Y N Lupus
Y N Mitral Valve Prolapse
Y N Pacemaker
Y N Persistent Cough
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic Fever
Y N Scarlet Fever
Y N Seizures
Y N Shingles
Y N Sickle Cell Disease
Y N Sinus Problems
Y N Steroid Therapy
Y N Stroke
Y N Thyroid Problems
Y N Tonsillitis
Y N Tuberculosis (TB)
Y N Ulcers
Y N Venereal Disease

Please list any serious medical condition(s) that you have experienced: ____________________

AUTHORIZATIONS

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need. My method of payment will be ____________________.

____________________ Signature Date

PAYMENT IS DUE AT TIME OF SERVICE

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I certify that I am covered by ____________________ Insurance Co. and I assign directly to Dr. ____________________ all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

____________________ Signature Date

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