

Dental Health History

Reason for today's visit _____

Previous Dentist _____ Address _____

Date of last dental visit _____ Last x-rays _____

Please indicate if you have had a problem with any of the following conditions:

- | | | |
|--|--|---|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Grinding Teeth | <input type="checkbox"/> Sensitivity to Hot or Cold |
| <input type="checkbox"/> Bleeding Gums | <input type="checkbox"/> Loose teeth / Broken Fillings | <input type="checkbox"/> Sensitivity to Sweets |
| <input type="checkbox"/> Clicking or Popping Jaw | <input type="checkbox"/> Periodontal "gum" Problems | <input type="checkbox"/> Sensitivity to Biting |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sores or growths in mouth | <input type="checkbox"/> Other |

Are you thinking about changing the overall appearance of your teeth? If so, how? _____

How often do you floss? _____

Medical History

Physician's name _____ Date of last visit _____

Previous hospitalizations, illnesses, or operations _____

Ladies: Are you pregnant yes no Nursing? yes no Taking Birth control? yes no

Has your physician ever told you to be premedicated with antibiotics prior to any dental treatment? yes no

Please check if you have or have had any of the following conditions:

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cough up Blood | <input type="checkbox"/> HIV | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Heart | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain/clicking | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Swelling of Feet/ankles |
| <input type="checkbox"/> Back Problem | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Describe _____ | <input type="checkbox"/> Radiation Tx | <input type="checkbox"/> Ulcers |
| | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Recreational Drugs | <input type="checkbox"/> Venereal Disease |

Please list any medications you are currently taking _____

Please list all allergies _____

Authorization

I have reviewed this questionnaire and answered its questions accurately, to the best of my knowledge. I understand that the answers I have provided will be used by the dentist to determine appropriate dental treatment, and I agree to notify the dentist if any change in my health status should occur.

I authorize the dentist to release all information necessary to secure payment of benefits. I authorize my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize use of this signature on all Insurance submissions.

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.

Signature _____ Date _____

(Parents please sign if patient is a minor)

PAYMENT IS DUE IN FULL AT TIME OF SERVICE UNLESS ARRANGEMENTS HAVE BEEN APPROVED

(Please continue on to next page)