

DENTAL HISTORY

Former Dentist _____

City, State _____

Date of Last Dental Visit _____

Date of Last X-Rays _____

How Often Do You Floss? _____

How Often Do You Brush? _____

Please check all that apply:

Bad Breath..... ☐
 Bleeding Gums ☐
 Blisters on Lips or Mouth ☐
 Finger Nail Biting ☐
 Grinding Teeth ☐
 Lip or Cheek Biting ☐

Loose Teeth or Broken Fillings..... ☐
 Orthodontic Treatment ☐
 Pain Around Ear ☐
 Periodontal Treatment ☐
 Sensitivity to Cold ☐
 Sensitivity to Heat ☐

Sensitivity to Sweets ☐
 Sensitivity When Biting ☐
 Frequent Headaches ☐
 Jaw, Head or Neck Injuries ☐
 Jaw Difficulty: Clicking and/or Pain..... ☐
 Tooth Pain ☐

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

1. Are you currently under medical treatment? ☐ Yes ☐ No

2. Have you ever had any serious illnesses or operations? ☐ Yes ☐ No

3. Are you currently taking any medication? ☐ Yes ☐ No

Please describe: _____

4. Do you smoke? ☐ Yes ☐ No

5. Do you use alcohol, cocaine or other drugs? ☐ Yes ☐ No

6. Do you wear contact lenses? ☐ Yes ☐ No

7. Have you had any allergic reactions to the following:

	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Local Anesthetics (eg. novocaine)	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates (sleeping pills)	<input type="checkbox"/>	<input type="checkbox"/>
Sedatives	<input type="checkbox"/>	<input type="checkbox"/>
Iodine	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>

8. (Women Only) Are You:

Pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Nursing?	<input type="checkbox"/>	<input type="checkbox"/>
Taking birth control pills?	<input type="checkbox"/>	<input type="checkbox"/>

Please check all that apply:

AIDS ☐
 Anemia..... ☐
 Arthritis, Rheumatism ☐
 Artificial Heart Valves ☐
 Artificial Joints ☐
 Asthma ☐
 Back Problems ☐
 Bleeding abnormally, with extractions or surgery ☐
 Blood Disease ☐
 Cancer ☐
 Chemical Dependency ☐
 Chemotherapy ☐
 Chronic Fatigue Syndrome ☐
 Circulatory Problems ☐
 Congenital Heart Lesions..... ☐
 Cortisone Treatments ☐
 Cough - persistent or bloody..... ☐
 Diabetes..... ☐

Emphysema ☐
 Epilepsy ☐
 Fainting or Dizziness ☐
 Glaucoma ☐
 Headaches..... ☐
 Heart Murmur ☐
 Heart Problems..... ☐
 Hepatitis-Type ☐
 Herpes..... ☐
 High Blood Pressure ☐
 HIV Positive ☐
 Jaundice ☐
 Jaw Pain ☐
 Latex Sensitivity ☐
 Kidney Disease ☐
 Liver Disease..... ☐
 Low Blood Pressure ☐
 Mitral Valve Prolapse..... ☐
 Nervous Problems..... ☐

Pacemaker..... ☐
 Psychiatric Care ☐
 Radiation Treatment..... ☐
 Respiratory Disease..... ☐
 Rheumatic Fever ☐
 Scarlet Fever ☐
 Shortness of Breath ☐
 Sinus Trouble..... ☐
 Skin Rash ☐
 Stroke ☐
 Swelling of Feet/Ankles..... ☐
 Swollen Neck Glands..... ☐
 Thyroid Problems..... ☐
 Tonsillitis ☐
 Tuberculosis..... ☐
 Tumor or growth on head/neck..... ☐
 Ulcer..... ☐
 Venereal Disease ☐

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to _____ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____