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5		DENTAL INF	FORMATION
five	Reason for today's visit:  Exam  Are you in pain?  No Yes How Lon	0 ,	nsultation
JOVO	Please indicate any of the following pr	•	
U	☐ Discomfort, clicking or popping in jaw.	☐ Lost/Broken Filling(s	s) 🖵 Stained teeth
A Section 1	Red, swollen or bleeding gums.	Teeth grinding	Locking Jaw
	☐ Sensitive tooth, teeth or gums.	0 0	
	☐ Blisters/Sores in or around the mouth.	□ Broken/Chipped too	th
	☐ Other:		
	Do you require pre-medication?   Yes	■ No ■ Don't know	
The second secon	Previous Dentist:	(	)

What type of tooth brush bristles do you use? ☐ Soft ☐ Medium

How would you rate your smile? (Worst) 1 2 3 4 5

Name

Last Dental exam:

Times a day you brush?



## MEDICAL LISTORY

Last Dental X-rays:\_

Times a week you floss?

6 7

Are you taking any of the following medications?							
Do you have or have you had any of the following diseases, medical conditions or procedures? Y N Heart Attack / Stroke Y N Thyroid Problems Y N Cancer/Tumors Y N Chemotherate Y N Carler frequent Y N Carler						7E	
Y N Heart Attack / Stroke Y N Heart Surg./Pacemaker Y N Heart Surg./Pacemaker Y N Heart Murmur Y N Liver Problems Y N Hepatitis Y N Hepatitis Y N Hepatitis Y N Arthritis/ Rheumatism Y N Arthritis/ Rheumatism Y N Arthritis/ Rheumatism Y N Arthritis/ Rheumatism Y N Diabetes/Hypoglycemia Y N Pesychiatric Problems Y N Arthritis/ Rheumatism Y N Diabetes/Hypoglycemia Y N Diabetes/Hypoglycemia Y N Leukemia Y N Leukemia Y N Congenital Heart Defect Y N Venereal Disease Y N Psychiatric Problems Y N Congenital Heart Defect Y N Venereal Disease Y N Psychiatric Problems Y N Scarlet Fever Y N Tuberculosis TB Y N Nervousness Y N Jaw Problems TMJ/TMD Y N Back Problems Y N Back Problems Y N Glaucoma  Please list any other surgeries or medical conditions you have or ever had:  Are you allergic to any of the following? Latex Do you use tobacco? No Yes/How used? Please rate your general health from 1-10: Do you wear contact lenses? Yes No For women: Are you taking Birth Control pills? Yes No How many children have you had?	☐ Other(s), please list: _						
Y N Heart Attack / Stroke Y N Heart Surg./Pacemaker Y N Heart Surg./Pacemaker Y N Heart Murmur Y N Liver Problems Y N Hepatitis Y N Arthritis/ Rheumatism Y N Arthritis/ Rheumatism Y N Arthritis/ Rheumatism Y N Arthritis/ Rheumatism Y N Diabetes/Hypoglycemia Y N Arthritis/ Rheumatism Y N Diabetes/Hypoglycemia Y N Heart Disease Y N Psychiatric Problems Y N Heart Disease Y N Psychiatric Problems Y N Heart Disease Y N Psychiatric Problems Y N Congenital Heart Defect Y N Venereal Disease Y N Achonl/Drug Abuse Y N Scarlet Fever Y N Tuberculosis TB Y N Frequent Neck Pain Y N Back Problems Y N Back Problems Y N Back Problems Y N Glaucoma  Please list any other surgeries or medical conditions you have or ever had:  Are you allergic to any of the following?  Latex Do you use tobacco?  No Yes/How used? Please rate your general health from 1-10: Do you wear contact lenses?  New Yes No How many children have you had? For women: Are you taking Birth Control pills?  Yes No How many children have you had?		had any of the followi	ng diseas	es. medical cor	nditions o	or procedur	es?
Y N Heart Surg./Pacemaker Y N Heart Murmur Y N Liver Problems Y N Hepatitis Y N Arthritis/ Rheumatism Y N Difficulty Breathing Y N Patitical Bones/Joints Y N Prequent Neck Pain Y N Partificial Bones/Joints Y N Prequent Neck Pain Y N Partificial Bones/Joints Y N Prequent Neck Pain Y N Partificial Bones/Joints Y N Prequent Neck Pain Y N Bleeding Problems Y N Prequent Neck Pain Y N Bleeding Problems Y N Prequen							
Y N Heart Murmur Y N Liver Problems Y N Rheumatic Fever Y N Respiratory Problems Y N Hilv-/AIDS/ARC Y N Mitral Valve Prolapse Y N Sinus Problems Y N Artificial Polems Y N Artificial Polems Y N Artificial Bones/Joints Y N Difficulty Breathing Y N Difficulty Breathing Y N Diabetes/Hypoglycemia Y N Congenital Heart Defect Y N Venereal Disease Y N Psychiatric Problems Y N Congenital Heart Defect Y N Venereal Disease Y N Painting/Seizures/Epilepsy Y N Artificial Polems Y N Scarlet Fever Y N Tuberculosis TB Y N Frequent Neck Pain Y N Back Problems Y N Back Problems Y N Back Problems Y N Glaucoma  Please list any other surgeries or medical conditions you have or ever had:  Are you allergic to any of the following?  Dental Anesthetics Others:  Do you use tobacco? No Yes/How used? How much? How long?  Please rate your general health from 1-10: Do you wear contact lenses? Y N Se N Hepatitis Y N Hepatitis Y N Hepatitits Y N Hepatitits Y N Hepatitits Y N HevAt/AIDS/ARC Y N Artifricial Bones/Joints Y N Difficulty Breathing Y N Diabetes/Hypoglycemia Y N Leukemia Y N Leukemia Y N Severe/Frequent Headaches Y N High/Low Blood Pressu Y N Frequent Neck Pain Y N Bleeding Problems Y N Glaucoma  Please list any other surgeries or medical conditions you have or ever had:  Dental Anesthetics Others:  Do you use tobacco? No Yes/How used? How much? How long?  Please rate your general health from 1-10: Do you wear contact lenses? Yes N Nervouses N Hearthritis/Rheumatism Y N Difficulty N N Difficulty N Difficulty N N Difficulty N N Difficulty N Difficulty N D	Y N Heart Surg./Pacemaker	•					
Y N Rheumatic Fever Y N Mitral Valve Prolapse Y N Artificial Valves Y N Stomach Problems Y N Artificial Oalves Y N Psychiatric Problems Y N Congenital Heart Defect Y N Venereal Disease Y N Congenital Heart Defect Y N Venereal Disease Y N Congenital Heart Defect Y N Venereal Disease Y N Congenital Heart Defect Y N Venereal Disease Y N Congenital Heart Defect Y N Venereal Disease Y N Congenital Heart Defect Y N Venereal Disease Y N Carlet Fever Y N Tuberculosis TB Y N Jaw Problems TMJ/TMD Y N Back Problems Y N Glaucoma  Please list any other surgeries or medical conditions you have or ever had:  Are you allergic to any of the following? Latex Do you use tobacco? No Yes/How used? Do you use tobacco? No Yes/How used? Please rate your general health from 1-10: Do you wear contact lenses? Yes No How many children have you had? For women: Are you taking Birth Control pills? Yes No How many children have you had?	S .	,		0			
Y N Mitral Valve Prolapse Y N Sinus Problems Y N Artificial Valves Y N Stomach Problems/Ulcers Y N Heart Disease Y N Psychiatric Problems Y N Congenital Heart Defect Y N Venereal Disease Y N Scarlet Fever Y N Tuberculosis TB Y N Mervousness Y N Jaw Problems TMJ/TMD Y N Back Problems Y N Back Problems Y N Glaucoma  Please list any other surgeries or medical conditions you have or ever had:  Are you allergic to any of the following? Latex Do you use tobacco? No Yes/How used? Do you use tobacco? No Yes/How used? Please rate your general health from 1-10: Do you wear contact lenses? Yes No How many children have you had? For women: Are you taking Birth Control pills? Yes No How many children have you had?	Y N Rheumatic Fever	Y N Respiratory Problem					, ,
Y N Artificial Valves Y N Psychiatric Problems Y N Psychiatric Problems Y N Congenital Heart Defect Y N Venereal Disease Y N Alcohol/Drug Abuse Y N Scarlet Fever Y N Tuberculosis TB Y N Jaw Problems TMJ/TMD Y N Back Problems Y N Bleeding Problems Y N Glaucoma  Please list any other surgeries or medical conditions you have or ever had:  Are you allergic to any of the following? Latex Penicillin / Amoxicillin Tetracycline Aspirin Do you use tobacco? No Yes/How used? Please rate your general health from 1-10: Do you wear contact lenses? Yes N How many children have you had?  Provided the problems of the following in the problems of the problems	Y N Mitral Valve Prolapse	, ,		Arthritis/ Rheuma	atism		
Y N Heart Disease Y N Psychiatric Problems Y N Congenital Heart Defect Y N Venereal Disease Y N Chest Pains Y N Chest Pains Y N Scarlet Fever Y N Tuberculosis TB Y N Psychiatric Problems Y N Severe/Frequent Headaches Y N High/Low Blood Pressu Y N Severe/Frequent Neck Pain Y N Back Problems Y N Back Problems Y N Glaucoma  Please list any other surgeries or medical conditions you have or ever had:  Are you allergic to any of the following?  Latex  Penicillin / Amoxicillin  Tetracycline  Aspirin Dental Anesthetics  Others:  Do you use tobacco?  No Yes/How used?  How much? How long?  Please rate your general health from 1-10:  Do you wear contact lenses?  Yes  New Yes  No How many children have you had?	Y N Artificial Valves	Y N Stomach Problems/U	Jicers Y N	Artificial Bones/Je	oints		,
Y N Congenital Heart Defect Y N Venereal Disease Y N Chest Pains Y N Alcohol/Drug Abuse Y N Scarlet Fever Y N Tuberculosis TB Y N Back Problems Y N Back Problems Y N Back Problems Y N Glaucoma  Please list any other surgeries or medical conditions you have or ever had:  Are you allergic to any of the following? Latex Dental Anesthetics Others:  Do you use tobacco? No Yes/How used?  Please rate your general health from 1-10:  Do you wear contact lenses? Yes N High/Low Blood Pressu Y N Frequent Neck Pain Y N Bleeding Problems Y N Glaucoma  Y N Glaucoma  Penicillin / Amoxicillin Tetracycline Aspirin Do you wear contact lenses? Yes N How many children have you had?  Por women: Are you taking Birth Control pills? Yes No How many children have you had?							71 07
Y N Chest Pains Y N Scarlet Fever Y N Tuberculosis TB Y N Back Problems Y N Back Problems Y N Back Problems Y N Glaucoma  Please list any other surgeries or medical conditions you have or ever had:  Are you allergic to any of the following? Latex Penicillin / Amoxicillin Tetracycline Aspirin Dental Anesthetics Others:  Do you use tobacco? No Yes/How used?  Please rate your general health from 1-10:  Do you wear contact lenses? Y N High/Low Blood Pressu Y N Severe/Frequent Headaches Y N High/Low Blood Pressu Y N Severe/Frequent Headaches Y N High/Low Blood Pressu Y N Severe/Frequent Headaches Y N High/Low Blood Pressu Y N Severe/Frequent Headaches Y N High/Low Blood Pressu Y N Severe/Frequent Headaches Y N High/Low Blood Pressu Y N Severe/Frequent Headaches Y N High/Low Blood Pressu Y N Severe/Frequent Headaches Y N High/Low Blood Pressu Y N Severe/Frequent Headaches Y N High/Low Blood Pressu Y N Severe/Frequent Headaches Y N High/Low Blood Pressu Y N Severe/Frequent Headaches Y N High/Low Blood Pressu Y N Severe/Frequent Headaches Y N High/Low Blood Pressu Y N Scarlet Fever Y N Scarlet Fever Y N Frequent Neck Pain Y N Bleeding Problems Y N Glaucoma  Please list any other surgeries or medical conditions you have or ever had:  Penicillin / Amoxicillin  Tetracycline  Aspirin Do you use tobacco? No  Yes/How used?  How much?  Do you wear contact lenses? Y N High/Low Blood Pressu Y N Frequent Neck Pain Y N Back Problems Y N Bleeding Problems Y N Glaucoma					/Epilepsy		
Y N Scarlet Fever Y N Nervousness Y N Jaw Problems TMJ/TMD Y N Back Problems Y N Glaucoma  Please list any other surgeries or medical conditions you have or ever had:  Are you allergic to any of the following? Latex Penicillin / Amoxicillin Tetracycline Aspirin Dental Anesthetics Others:  Do you use tobacco? No Yes/How used?  Please rate your general health from 1-10:  Do you wear contact lenses? Y N Bleeding Problems Y N Glaucoma  Phow much:  Do you wear contact lenses?  Y N Bleeding Problems Y N Bleeding Problems Y N Bleeding Problems Y N Glaucoma  Please rate you allergic to any of the following?  Do you wear contact lenses?  Y N Bleeding Problems Y N Glaucoma	•						
Y N Jaw Problems TMJ/TMD Y N Back Problems Y N Glaucoma  Please list any other surgeries or medical conditions you have or ever had:  Are you allergic to any of the following? Latex Penicillin / Amoxicillin Tetracycline Aspirin  Dental Anesthetics Others:  Do you use tobacco? No Yes/How used?  How much?  How long?  Please rate your general health from 1-10:  Do you wear contact lenses? Y N Glaucoma  How long?  Please rate your general health from 1-10:  New you ever taken the drug Phen-fen and or Redux? Yes No  For women: Are you taking Birth Control pills? Yes No How many children have you had?		9					
Please list any other surgeries or medical conditions you have or ever had:  Are you allergic to any of the following?  Latex  Penicillin / Amoxicillin  Tetracycline  Aspirin  Dental Anesthetics  Others:  Do you use tobacco?  No  Yes/How used? How much? How long?  Please rate your general health from 1-10:  Do you wear contact lenses? Yes  No Have you ever taken the drug Phen-fen and or Redux? Yes  No How many children have you had?							•
□ Dental Anesthetics □ Others:  Do you use tobacco? □ No □ Yes/How used?  Please rate your general health from 1-10:  Do you wear contact lenses? □ Yes □ No Have you ever taken the drug Phen-fen and or Redux? □ Yes □ No How many children have you had?							ne 🛚 Aspirin
Please rate your general health from 1-10: Do you wear contact lenses? □ Yes □ N Have you ever taken the drug Phen-fen and or Redux? □ Yes □ No For women: Are you taking Birth Control pills? □ Yes □ No How many children have you had?							•
Have you ever taken the drug Phen-fen and or Redux? ☐ Yes ☐ No  For women: Are you taking Birth Control pills? ☐ Yes ☐ No How many children have you had?	Do you use tobacco?	No ☐ Yes/How used	?	How	/ much?	Н	ow long?
Are you Pregnant? ☐ No ☐ Yes/How long? Are you nursing? ☐ Yes ☐ No	Have you ever taken the	e drug Phen-fen and	or Redux	? □ Yes □ No	)		
	Are you Pregnant?   N	lo □ Yes/How long?_		Are you nursir	ng? 🗅 Ye	es 🗅 No	

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■ We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.

- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature				Date	/	/	
•	☐ Adult Patient	Parent or Guardian	☐ Spouse				