Name_____Date_____
Address_____Phone_____
Former Dentist_____Address_____Phone_____

Dental History

Check (/) if you have had problems with any of the following:

__Bad Breath __ Food collection between teeth __ Periodontal treatment __Sensitivity to sweets
__Bleeding gums __ Grinding or clenching teeth __ Sensitivity to cold __Sensitivity when biting
__Clicking or popping of jaw __Loose teeth or broken fillings __Sensitivity to hot __Sores or growths in mouth

How often do you brush your teeth?_____ Floss?_____
Have your ever experienced an adverse reaction during or in conjunction with a dental procedure? ____Yes or ___No

Medical History

Physician's Name_____Phone_____
Date of last visit_____ Have you had any serious illnesses or operations? ____Yes or ____No
If yes, please describe_____
Are you currently under a physician's care? ___Yes or ___ No If yes, describe_____
Have you ever had a blood transfusion? ___Yes or ___No If yes, give approximate dates _____
Women: Are you pregnant? ___Yes or ___No Nursing? ___Yes or ___No Are you taking Birth control pills? ___Yes or ___No

CHECK (/) if you have had any of the following :

____ AIDS/HIV Positive
____ Allergies
____ Anaphylaxis
____ Anemia
____ Angina
____ Anxiety Attacks
____ Arthritis, Rheumatism
____ Artificial Heart Valves
____ Artificial Joints
____ Asthma
____ Atopic (allergy prone)
____ Back Problems
____ Blood Disorders
____ Cancer
Describe _____
____ Chemical Dependency
____ Chemotherapy
____ _____
____ Cough, persistent
____ Cough up blood
____ Diabetes
____ Epilepsy
____ Fainting
____ Food Allergies
____ Glaucoma
____ Headaches
____ Heart Murmur
____ Heart Problems
Describe_____
____ Heart Surgery
____ Hemophilia / Abnormal bleeding
____ Herpes
____ Hepatitis
____ Hernia
____ Hypoglycemia
____ High Cholesterol
____ High Blood Pressure
____ Jaw Pain
____ Kidney Problems
____ Liver Disease
____ Low Blood Pressure
____ Lupus
____ Material Allergies
(latex, metals, chemicals)
____ Mitral Valve Prolapse
____ Multiple Sclerosis
____ Nervous Problems
____ Pacemaker
____ Psychiatric Care
____ Rapid Weight gain or loss
____ Radiation Treatment
____ Respiratory Disease
____ Rheumatic Fever
____ Scarlet Fever
____ Seizures
____ Shingles
____ Shortness of breath
____ Sinus Problems
____ Skin Rash
____ Steroid Treatment
____Stomach Problems
____ Stroke
____ Surgical Implant
____ Swelling (feet/ankles)
____ Thyroid Problems
____ Tobacco Habit
____ Tuberculosis
____ Tumors
____ Ulcers/ Colitis
____ Venereal Disease
____ Weight loss
____ _____

List Medications you are currently taking, if any:

_____
_____
_____

List Drug Allergies, if any:

_____
_____
_____

AUTHORIZATION

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 a change in medical status, I will inform the dentist.

SIGNATURE _____ **DATE** _____

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for service 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. Thank you.