

Patient's Name: \_\_\_\_\_

# DENTAL HISTORY

Date: \_\_\_\_\_

What is the reason for your visit today? \_\_\_\_\_

Date of Last Dental Visit: \_\_\_\_\_ Last Cleaning: \_\_\_\_\_

Were Any X-Rays taken?    YES    NO

Previous Dentist: \_\_\_\_\_ Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

(Street)

(City)

(State)

(Zip)

Do you have any dental problems now?    YES    NO

If YES, please describe: \_\_\_\_\_

**Are your teeth sensitive:**

Hot / Cold.....    YES    NO

Sweets .....    YES    NO

**Have you ever had:**

Orthodontic treatment.....    YES    NO

Oral surgery.....    YES    NO

Periodontal treatment.....    YES    NO

Your teeth ground or bite adjusted.....    YES    NO

A mouth guard .....    YES    NO

A serious injury to the mouth / head.....    YES    NO

**Have you experienced:**

Clicking or popping of the jaw.....    YES    NO

Pain (joint, ear, side of face).....    YES    NO

Difficulty in opening or closing mouth.....    YES    NO

Difficulty in chewing on either side of mouth.....    YES    NO

Headaches, neckaches or shoulder aches.....    YES    NO

Are you satisfied with your teeth's appearance?.....    YES    NO

Do you feel nervous about having dental treatment?.....    YES    NO

If YES, what is your biggest concern?.....    YES    NO

Is there anything else about having dental treatment that you would like us to know?.....    YES    NO

If YES, please describe: \_\_\_\_\_

I UNDERSTAND THAT ALL THE INFORMATION THAT I HAVE GIVEN IS NECESSARY TO PROVIDE ME WITH DENTAL CARE IN A SAFE AND EFFICIENT MANNER. I HAVE ANSWERED ALL QUESTIONS TO THE BEST OF MY KNOWLEDGE. SHOULD FURTHER INFORMATION BE NEEDED, YOU HAVE MY PERMISSION TO ASK THE RESPECTIVE HEALTH CARE PROVIDER, WHO MAY RELEASE SUCH INFORMATION TO YOU. I WILL NOTIFY THE DOCTOR OF ANY CHANGE IN MY HEALTH OR MEDICATION.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**HISTORY REVIEW**

Assistant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Continued on back)

# HEALTH / DENTAL HISTORY

We are a health-centered dental practice, thus we are concerned with your total well-being, not just your oral health. Please fill out the health questionnaire below completely – even if some of the questions may not seem relevant to your dental health. **All information is completely confidential.** (Circle YES or NO)

1. Have you been under the care of a physician during the past two years? ..... **YES** **NO**

If yes, for what? \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

2. Are you taking medication, drugs or pills now? ..... **YES** **NO**

If YES, please list name / dosage \_\_\_\_\_

3. Have you ever taken Fen-Phen or other dietary aids?..... **YES** **NO**

4. Have you been hospitalized in the last 5 years?..... **YES** **NO**

5. Are you aware of having an allergic (or adverse reaction) to any medication?..... **YES** **NO**

If YES, please list \_\_\_\_\_

6. Have you had unfavorable reactions to any of the following? (Please circle)

- |         |         |                   |           |       |            |
|---------|---------|-------------------|-----------|-------|------------|
| ASPIRIN | CODEINE | LOCAL ANESTHETICS | SEDATIVES | SULFA | PENICILLIN |
|         | LATEX   | FOOD ALLERGIES    | FOOD DYES |       |            |

7. Were you ever required to take an antibiotic premedication for dental treatment due to any of the following medical conditions? (Please circle)

- |                 |                                    |                       |
|-----------------|------------------------------------|-----------------------|
| HEART MURMUR    | ARTIFICIAL HEART VALVE             | MITRAL VALVE PROLAPSE |
| PNEUMATIC FEVER | ARTIFICIAL JOINT (hip, knee, etc.) |                       |

8. Indicate which of the following you have had, or have at present. (Circle YES or NO)

Organ Transplant.....	<b>YES</b>	<b>NO</b>	Chronic Cough.....	<b>YES</b>	<b>NO</b>
Heart (Surgery, Disease, Attack) .....	<b>YES</b>	<b>NO</b>	Tuberculosis .....	<b>YES</b>	<b>NO</b>
Chest Pain.....	<b>YES</b>	<b>NO</b>	Asthma .....	<b>YES</b>	<b>NO</b>
Congenital Heart Disease.....	<b>YES</b>	<b>NO</b>	Allergies .....	<b>YES</b>	<b>NO</b>
Heart Murmur.....	<b>YES</b>	<b>NO</b>	Radiation Treatments .....	<b>YES</b>	<b>NO</b>
High Blood Pressure .....	<b>YES</b>	<b>NO</b>	Malignancies / Cancer .....	<b>YES</b>	<b>NO</b>
Artificial Heart Valve.....	<b>YES</b>	<b>NO</b>	Hepatitis A (infectious).....	<b>YES</b>	<b>NO</b>
Heart Pacemaker .....	<b>YES</b>	<b>NO</b>	Hepatitis B (serum) .....	<b>YES</b>	<b>NO</b>
Rheumatic Fever .....	<b>YES</b>	<b>NO</b>	Non-A Non-B Hepatitis.....	<b>YES</b>	<b>NO</b>
Arthritis / Rheumatism .....	<b>YES</b>	<b>NO</b>	A.I.D.S. ....	<b>YES</b>	<b>NO</b>
Stroke / Use of Blood Thinners.....	<b>YES</b>	<b>NO</b>	HIV Positive.....	<b>YES</b>	<b>NO</b>
Artificial Joint (Hip, Knee, etc.).....	<b>YES</b>	<b>NO</b>	Canker / Cold Sores / Fever Blisters....	<b>YES</b>	<b>NO</b>
Kidney Trouble.....	<b>YES</b>	<b>NO</b>	Blood Transfusions.....	<b>YES</b>	<b>NO</b>
Ulcers .....	<b>YES</b>	<b>NO</b>	Anemia .....	<b>YES</b>	<b>NO</b>
Diabetes .....	<b>YES</b>	<b>NO</b>	Epilepsy / Seizures .....	<b>YES</b>	<b>NO</b>
Thyroid Problems .....	<b>YES</b>	<b>NO</b>	Fainting / Blackouts .....	<b>YES</b>	<b>NO</b>
Glaucoma.....	<b>YES</b>	<b>NO</b>	Nervous Disorders .....	<b>YES</b>	<b>NO</b>
Emphysema .....	<b>YES</b>	<b>NO</b>	Psychiatric / Psychological Care.....	<b>YES</b>	<b>NO</b>
Female: Are you pregnant and/or nursing? ...	<b>YES</b>	<b>NO</b>			

*(Continued on back)*

# Patient Information

Mr   Mrs   Miss   Ms                      (Circle One)                      Male                      Female

(Last Name)                                      (First Name)                                      (Middle Initial)

Preferred Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Social Security # \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Home Address: \_\_\_\_\_

(Street)                                      (City)                                      (State)                                      (Zip)

Billing Address: \_\_\_\_\_

(Street or PO Box)                                      (City)                                      (State)                                      (Zip)

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Person to Contact in Case of Emergency: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Who Referred You to Our Office? \_\_\_\_\_ If Not Referred How Did You Find Us? \_\_\_\_\_

If this Appointment Is For Your Child - Who Does Child Live With: (Circle One) Father   Mother   Both Parents

School That He/She Attends: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Mother's Name: \_\_\_\_\_

Father's Employer: \_\_\_\_\_ Mother's Employer: \_\_\_\_\_

Father's Work Phone: \_\_\_\_\_ Mother's Work Phone: \_\_\_\_\_

## Dental Insurance, Please Provide Your Insurance Card

I hereby authorize the release of any information including the diagnosis and the records of any treatments or examinations rendered, to my insurance company or companies. This release is solely for the purpose of facilitating the billing and reimbursement, directly to the dentist, of insurance benefits under which I am entitled.

I agree to be responsible for payments of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

Responsible Party: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_