

# Dental History

Name \_\_\_\_\_ Age \_\_\_\_\_

Former Dentist \_\_\_\_\_

Reason for today's visit \_\_\_\_\_

Date of last exam \_\_\_\_\_ Date of last dental X-rays \_\_\_\_\_

How often do you brush? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

Please check any of the following conditions that apply to you:

- |                                                        |                                                         |                                                         |
|--------------------------------------------------------|---------------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Bad breath                    | <input type="checkbox"/> Grinding teeth                 | <input type="checkbox"/> Sensitivity to hot             |
| <input type="checkbox"/> Bleeding gums                 | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets          |
| <input type="checkbox"/> Clicking or popping jaw       | <input type="checkbox"/> Periodontal treatment          | <input type="checkbox"/> Sensitivity when biting        |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold            | <input type="checkbox"/> Sores or growths in your mouth |

# Medical History

Physician \_\_\_\_\_ Date of last visit \_\_\_\_\_

Please list all medications you are currently taking: \_\_\_\_\_

Allergies: \_\_\_\_\_

(Women) Are you pregnant?  Yes  No      Nursing?  Yes  No      Taking birth control pills?  Yes  No

Do you have a history of the following? \_\_\_\_\_

- |                                                  |                                               |                                                |                                                     |
|--------------------------------------------------|-----------------------------------------------|------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> AIDS                    | <input type="checkbox"/> Cortisone treatments | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Rheumatic fever            |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Cough, persistent    | <input type="checkbox"/> High blood pressure   | <input type="checkbox"/> Scarlet fever              |
| <input type="checkbox"/> Arthritis, rheumatism   | <input type="checkbox"/> Cough up blood       | <input type="checkbox"/> HIV positive          | <input type="checkbox"/> Shortness of breath        |
| <input type="checkbox"/> Artificial heart valves | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Jaw pain              | <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 or ankles |
| <input type="checkbox"/> Back problems           | <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"/> Chemical dependency     | <input type="checkbox"/> Heart problems       | <input type="checkbox"/> Psychiatric care      | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Chemotherapy            | Describe _____                                | <input type="checkbox"/> Radiation treatment   | <input type="checkbox"/> Ulcer                      |
| <input type="checkbox"/> Circulatory problems    | <input type="checkbox"/> Hemophilia           | <input type="checkbox"/> Respiratory disease   | <input type="checkbox"/> Venereal disease           |

# Authorization

*I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. 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 or me dependents.*

**X**

SIGNATURE OF PATIENT (Or parent if a minor)

DATE