Dental History

Reason for Today's Visit ___

Former Dentist Name ___ Phone ( ) ___

Date of Last Dental Care ___ Date of Last Dental X-rays ___

Mark YES or NO if you have had problems with any of the following:

☐ YES ☐ NO Bad breath	☐ YES ☐ NO Grinding teeth	☐ YES ☐ NO Sensitive to hot
☐ YES ☐ NO Bleeding gums	☐ YES ☐ NO Loose teeth or broken fillings	☐ YES ☐ NO Sensitive to sweet
☐ YES ☐ NO Clicking or popping jaw	☐ YES ☐ NO Periodontal treatment	☐ YES ☐ NO Sensitivity when biting
☐ YES ☐ NO Food collection between teeth	☐ YES ☐ NO Sensitive to cold	☐ YES ☐ NO Sores or growths in mouth

Medical History

Physician's Name ___ Date of Last Visit ___

Physician's Address ___ Phone ( ) ___

Have you had any serious illnesses or operations? ☐ YES ☐ NO If yes, describe ___

Do you need to use antibiotics before any medical or dental treatment? ☐ YES ☐ NO If yes, describe ___

Women: Are you pregnant? ☐ YES ☐ NO Nursing? ☐ YES ☐ NO Taking birth control pills? ☐ YES ☐ NO

Mark YES or NO if you have or have had any of the following:

☐ YES ☐ NO AIDS	☐ YES ☐ NO Cough, Persistent	☐ YES ☐ NO High Blood Pressure	☐ YES ☐ NO Scarlet Fever
☐ YES ☐ NO Anemia	☐ YES ☐ NO Cough up Blood	☐ YES ☐ NO HIV Positive	☐ YES ☐ NO Shortness of Breath
☐ YES ☐ NO Arthritis, Rheumatism	☐ YES ☐ NO Diabetes	☐ YES ☐ NO Jaw Pain	☐ YES ☐ NO Skin Rash
☐ YES ☐ NO Artificial Heart Valves	☐ YES ☐ NO Diet Medication	☐ YES ☐ NO Kidney Disease	☐ YES ☐ NO Stroke
☐ YES ☐ NO Artificial Joints	☐ YES ☐ NO Epilepsy	☐ YES ☐ NO Liver Disease	☐ YES ☐ NO Swelling of Feet or Ankles
☐ YES ☐ NO Asthma	☐ YES ☐ NO Fainting	☐ YES ☐ NO Mitral Valve Prolapse	☐ YES ☐ NO Thyroid Problems
☐ YES ☐ NO Back Problems	☐ YES ☐ NO Glaucoma	☐ YES ☐ NO Nervous Problems	☐ YES ☐ NO Tobacco Habit
☐ YES ☐ NO Blood Disease	☐ YES ☐ NO Headaches	☐ YES ☐ NO Pacemaker	☐ YES ☐ NO Tonsilitis
☐ YES ☐ NO Cancer	☐ YES ☐ NO Heart Murmur	☐ YES ☐ NO Phen-Fen Diet Plan	☐ YES ☐ NO Tuberculosis
☐ YES ☐ NO Chemical Dependency	☐ YES ☐ NO Heart Problems	☐ YES ☐ NO Psychiatric Care	☐ YES ☐ NO Ulcers
☐ YES ☐ NO Chemotherapy	Describe ___	☐ YES ☐ NO Radiation Treatment	☐ YES ☐ NO Venereal Disease
☐ YES ☐ NO Cortisone Treatments	☐ YES ☐ NO Hepatitis	☐ YES ☐ NO Rheumatic Fever	☐ YES ☐ NO Allergy to LATEX

MEDICATIONS

List all medications you are currently taking:

___

___

ALLERGIES

List all allergies you have:

___

___

Authorization

I declare that all information given are correct and true to the best of my knowledge. It is my responsibility to inform this office of any changes in my medical history and dental insurance status. I will not hold the dentist responsible for any omissions I have made in the completion of this form.
I authorize the dentist to perform all dental services agreed upon between the dentist and myself or guardian. I understand the use of anesthetics and other medications may be necessary and may pose a certain risk.
I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services 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.
I understand that payment is due in full at time of treatment unless prior arrangements have been approved.

Signature of Patient or Guardian ___ Date ___

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