

Patient Medical History

Patient's Name _____ Date of Birth _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

- | | Yes | No |
|--|-----|----|
| 1. Are you in good health? _____ | | |
| 2. Have there been any changes in your general health within the past year? _____ | | |
| 3. Date of your last physical exam _____ | | |
| 4. Physician's name _____ Address _____ Phone No. _____ | | |
| 5. Are you now under the care of a physician? _____ | | |
| 6. Have you ever been hospitalized for any surgical operation or serious illness? _____ Please explain _____ | | |
| 7. Are you taking any medicine(s), including non-prescription medicine? _____ If yes, what medicine(s) are you taking? _____ _____ | | |

- | | Yes | No |
|---|-----|----|
| 8. Have you had any abnormal bleeding? _____ | | |
| 9. Do you bruise easily? _____ | | |
| 10. Have you ever required a blood transfusion? _____ | | |
| 11. Have you had a recent weight loss? _____ | | |
| 12. Have you ever taken Fen-Phen or Redux? _____ | | |
| 13. Tobacco user? _____ snuff cigarettes cigar pipe chew | | |
| 14. Do you or have you used controlled substances? _____ | | |
| 15. Are you wearing contact lenses? _____ | | |

Women Only

- | | Yes | No |
|---|-----|----|
| 1. Are you pregnant or think you may be pregnant? _____ | | |
| 2. Are you nursing? _____ | | |
| 3. Are you taking birth control pills? _____ | | |

- | | Yes | No |
|--|-----|----|
| Are you allergic to or have you had reactions to: | | |
| Local anesthetics like Novocain _____ | | |
| Penicillin or other antibiotics _____ | | |
| Sulfa drugs _____ | | |
| Barbiturates, sedatives, or sleeping pills _____ | | |
| Aspirin _____ | | |
| Iodine _____ | | |
| Any metals (e.g., nickel, mercury, etc.) _____ | | |
| Latex/rubber _____ | | |
| Other (please list) _____ | | |

- | | Yes | No |
|---------------------------------------|-----|----|
| Fainting or dizzy spells _____ | | |
| Diabetes _____ | | |
| AIDS or HIV infection _____ | | |
| Thyroid problem _____ | | |
| Allergies _____ | | |
| Arthritis or rheumatism _____ | | |
| Joint replacement or implant _____ | | |
| Stomach ulcer _____ | | |
| Kidney trouble _____ | | |
| Tuberculosis _____ | | |
| Persistent cough _____ | | |
| Cough that produces blood _____ | | |
| Chemotherapy (cancer, leukemia) _____ | | |
| Sexually transmitted disease _____ | | |
| Epilepsy or seizures _____ | | |
| Anemia _____ | | |
| Glaucoma _____ | | |
| Nervousness _____ | | |
| Tonsillitis _____ | | |
| Tumors _____ | | |
| Mental health care _____ | | |
| Back problems _____ | | |
| Chemical dependency _____ | | |
| Cortisone treatment _____ | | |
| Cold sores/fever blisters _____ | | |
| Hypoglycemia _____ | | |
| Eating disorders _____ | | |

- Do you have, or have you ever had, any of the following:
- Rheumatic heart disease or rheumatic fever _____
 - Scarlet fever _____
 - Heart defect or heart murmur, mitral valve prolapse _____
 - Heart trouble, heart attack, or angina _____
 - Chest pain _____
 - Shortness of breath _____
 - Pacemaker _____
 - Heart surgery _____
 - High/low blood pressure _____
 - Congenital heart problem _____
 - Swelling of feet, ankles, hands _____
 - Hepatitis, jaundice, or liver disease _____
 - Stroke _____
 - Sinus trouble _____
 - Lung or breathing problems _____
 - Asthma or hay fever _____
 - Hives or skin rash _____

Patient Dental History

Patient's Name _____ Date of Birth _____

Reason for this visit _____

When was your last dental visit? _____ What was done then? _____

How often did you visit the dentist before then? _____

Previous dentist (name and location) _____

Have you had a complete series of dental exams (x-rays) taken? When and where _____

How often do you brush your teeth? _____ How often do you floss your teeth? _____

Is your drinking water fluoridated? _____

| | Yes | No | | Yes | No |
|--|-----|----|--|-----|----|
| Do your gums bleed while brushing or flossing? _____ | | | Have you noticed any loosening of your teeth? _____ | | |
| Are your teeth sensitive to hot or cold liquids/foods? _____ | | | Does food tend to become caught between your teeth? _____ | | |
| Are your teeth sensitive to sweet or sour liquids/foods? _____ | | | Have you ever had periodontal treatment (gums)? _____ | | |
| Do you feel pain to any of your teeth? _____ | | | Ever worn a bite plate or other appliance? _____ | | |
| Do you have any sores or lumps in or near your mouth? _____ | | | Have you ever had any difficult extractions in the past? _____ | | |
| Have you had any head, neck, or jaw injuries? _____ | | | Have you ever had any prolonged bleeding following extractions? _____ | | |
| Have you ever experienced any of the following problems in your jaw? | | | Do you wear dentures or partials? _____ | | |
| Clicking/popping _____ | | | If yes, date of placement _____ | | |
| Pain (joint, ear, side of face) _____ | | | Have you ever oral hygiene instructions regarding the care of your teeth and gums? _____ | | |
| Difficulty in opening or closing _____ | | | Have you had orthodontics/braces in the past? _____ | | |
| Difficulty in chewing _____ | | | Would you be interested in teeth whitening? _____ | | |
| Do you have frequent headaches? _____ | | | Have you had an unfavorable dental experience? _____ | | |
| Do you clench or grind your teeth? _____ | | | Do you require pre-medication for dental visits? _____ | | |
| Do you bite your lips or cheeks frequently? _____ | | | | | |
| Are you troubled with bad breath? _____ | | | | | |

If you could do anything about your smile, what would you change? _____

Appointments: A minimum charge will be made for failed or cancelled appointments without prior notification of 24 hours. Once an appointment is made, please remember this time with the hygienist or doctor has been reserved for just you.

Financial Policy: 1. For any crown and bridge appointments there will be a 5% CASH courtesy if paid when treatment begins. 2. Payment is expected when service are rendered. 3. Payment can be made in the form of Cash, Check, Debit or Credit Card. 4. Insurance: We will collect your estimated patient portion at the time of service 5. We try our best to estimate your insurance benefit portion, but if an unpaid balance is not paid in a timely manner we can no longer file your insurance.

Authorization and Release

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 my 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 payors 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 my dependents. I agree to pay collection costs and/or reasonable attorney's fee if a delinquent balance is referred to an agency or attorney for collection or suit.

X _____ Date _____
Signature of patient or parent if minor

