

-Dental Health History-

1. What is your greatest concern about your teeth? _____
2. Are you in pain at this time? _____ Is so, where? _____
3. Date of your last dental exam _____ Former Dentist _____
4. When was the last time you had x-rays taken of your teeth? _____
5. Do you like your smile? _____
6. Are you satisfied with how straight your teeth are? _____
7. Is there anything you would change about the color shape of your teeth? _____
8. Have you had any injuries involving the head, neck or jaw? _____
9. Do you have partials or dentures? _____ If so, how long? _____

PLEASE MARK ALL THAT APPLY WITH AN "X"

- | | | |
|--|---|--|
| <input type="checkbox"/> Teeth sensitive to cold, heat, sweets or biting
<input type="checkbox"/> Bleeding gums
<input type="checkbox"/> Periodontal Treatment
<input type="checkbox"/> Clenching or grinding
<input type="checkbox"/> Pain around ear
<input type="checkbox"/> Unusual sounds while eating
<input type="checkbox"/> Frequent headaches
<input type="checkbox"/> Wear a biteguard | <input type="checkbox"/> Food impaction
<input type="checkbox"/> Unpleasant taste
<input type="checkbox"/> Bad Breath
<input type="checkbox"/> Wisdom teeth removed
<input type="checkbox"/> Orthodontic treatment (braces)
<input type="checkbox"/> Unfavorable dental experience
<input type="checkbox"/> Swelling/lumps in the mouth | <input type="checkbox"/> Smoke/chew tobacco
<input type="checkbox"/> Texture of toothbrush _____
<input type="checkbox"/> Dental floss/frequency _____
<input type="checkbox"/> Water pik
<input type="checkbox"/> Rotary toothbrush
<input type="checkbox"/> Home Fluoride |
|--|---|--|

-Medical Health History-

Physician's name _____ Address _____ Phone _____

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING (PRESCRIPTION AND OVER THE COUNTER)

Name	Dosage	Name	Dosage	Name	Dosage

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? INDICATE WITH AN "X"

- | | | |
|---|--|--|
| <input type="checkbox"/> Allergies to antibiotics such as Penicillin, sulfa, etc...
<input type="checkbox"/> Allergies to local anesthetics or Nitrous oxide
<input type="checkbox"/> Allergies to aspirin, codeine narcotics, etc...
<input type="checkbox"/> Heart murmur
<input type="checkbox"/> Mitral valve prolapse
<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Heart ailments
<input type="checkbox"/> Heart attack
<input type="checkbox"/> Pacemaker/Defibrillator
<input type="checkbox"/> Angina Pectoris
<input type="checkbox"/> High or low blood pressure
<input type="checkbox"/> Artificial joints
<input type="checkbox"/> Pregnancy (month _____) | <input type="checkbox"/> Neurological problems
<input type="checkbox"/> Stroke
<input type="checkbox"/> Epilepsy or seizures
<input type="checkbox"/> Blood diseases
<input type="checkbox"/> Anemia
<input type="checkbox"/> Sickle cell disease
<input type="checkbox"/> Excessive bleeding from a cut or extraction
<input type="checkbox"/> Cancer
<input type="checkbox"/> Radiation
<input type="checkbox"/> Chemotherapy
<input type="checkbox"/> Liver problems
<input type="checkbox"/> Hepatitis type _____
<input type="checkbox"/> Kidney problems
<input type="checkbox"/> Recreational drug use
<input type="checkbox"/> Thyroid problems hypo/hyper | <input type="checkbox"/> Cortisone medication
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Persistent cough 3 wks. Or more
<input type="checkbox"/> Night sweats
<input type="checkbox"/> Bloody sputum
<input type="checkbox"/> Ulcer/Colitis
<input type="checkbox"/> AIDS/HIV positive/
Kaposi's Sarcoma
<input type="checkbox"/> Sexually transmitted disease
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Asthma
<input type="checkbox"/> Breathing/lung problems
<input type="checkbox"/> Psychiatric treatment
<input type="checkbox"/> Hay fever/general allergies
<input type="checkbox"/> Diabetes (Type I or II) |
|---|--|--|

List any other details of your medical history or any impending treatment that may possibly affect your dental health:

TREATMENT AUTHORIZATION: I hereby authorize the above named dentists and staff to administer dental treatment to the best of their professional knowledge, and to administer such drugs or anesthetic agents as they deem necessary in said treatment or in an emergency situation.

SIGNATURE ON FILE: I authorize use of this signature on all my insurance submissions, and I authorize release of information to insurance companies and I allow payment to be directed to the doctors. A copy of this authorization may be used in place of the original.

Date: _____ Signature of Responsible Party: _____