DENTAL HISTORY

Former Dentist _____ Date of Last X-Rays _____

City, State _____ How Often Do You Floss? _____

Date of Last Dental Visit _____ How Often Do You Brush? _____

Please check all that apply:

- Bad Breath ☐
- Bleeding Gums ☐
- Blisters on Lips or Mouth ☐
- Finger Nail Biting ☐
- Grinding Teeth ☐
- Lip or Cheek Biting ☐
- Loose Teeth or Broken Fillings ☐
- Orthodontic Treatment ☐
- Pain Around Ear ☐
- Periodontal Treatment ☐
- Sensitivity to Cold ☐
- Sensitivity to Heat ☐
- Sensitivity to Sweets ☐
- Sensitivity When Biting ☐
- Frequent Headaches ☐
- Jaw, Head or Neck Injuries ☐
- Jaw Difficulty: Clicking and/or Pain ☐
- Tooth Pain ☐

MEDICAL HISTORY

Physician's Name _____ Date of Last Visit _____

	Yes	No
1. Are you currently under medical treatment?	☐	☐
2. Have you ever had any serious illnesses or operations?	☐	☐
3. Are you currently taking any medication?	☐	☐

Please describe: *(Including Viagra, Fosamax, Actonel, Boniva or similar substance)*

_____

4. Do you smoke?	☐	☐
5. Do you use alcohol, cocaine or other drugs?	☐	☐
6. Do you wear contact lenses?	☐	☐

7. Have you had any allergic reactions to the following:

	Yes	No
Local Anesthetics (eg. novocaine)	☐	☐
Penicillin or other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates (sleeping pills)	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Latex	☐	☐

8. (Women Only) Are You:

Pregnant?	☐	☐
Nursing?	☐	☐
Taking birth control pills?	☐	☐

Please check all that apply:

	YES	NO
AIDS	☐	☐
Anemia	☐	☐
Arthritis, Rheumatism	☐	☐
Artificial Heart Valves	☐	☐
Artificial Joints	☐	☐
Asthma	☐	☐
Back Problems	☐	☐
Bleeding abnormally, with extractions or surgery	☐	☐
Blood Disease	☐	☐
Cancer	☐	☐
Chemical Dependency	☐	☐
Chemotherapy	☐	☐
Chronic Fatigue Syndrome	☐	☐
Circulatory Problems	☐	☐
Congenital Heart Lesions	☐	☐
Cortisone Treatments	☐	☐
Cough - persistent or bloody	☐	☐
Diabetes	☐	☐
Emphysema	☐	☐
Epilepsy	☐	☐
Fainting or Dizziness	☐	☐
Glaucoma	☐	☐
Headaches	☐	☐
Heart Murmur	☐	☐
Heart Problems	☐	☐
Hepatitis-Type _____	☐	☐
Herpes	☐	☐
High Blood Pressure	☐	☐
HIV Positive	☐	☐
Jaundice	☐	☐
Jaw Pain	☐	☐
Latex Sensitivity	☐	☐
Kidney Disease	☐	☐
Liver Disease	☐	☐
Low Blood Pressure	☐	☐
Mitral Valve Prolapse	☐	☐
Nervous Problems	☐	☐
Osteoporosis	☐	☐
Pacemaker	☐	☐
Psychiatric Care	☐	☐
Radiation Treatment	☐	☐
Respiratory Disease	☐	☐
Rheumatic Fever	☐	☐
Scarlet Fever	☐	☐
Shortness of Breath	☐	☐
Sinus Trouble	☐	☐
Skin Rash	☐	☐
Stroke	☐	☐
Swelling of Feet/Ankles	☐	☐
Swollen Neck Glands	☐	☐
Thyroid Problems	☐	☐
Tonsillitis	☐	☐
Tuberculosis	☐	☐
Tumor or growth on head/neck	☐	☐
Ulcer	☐	☐
Venereal Disease	☐	☐

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to _____ for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.

I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party _____ Date _____