## Dental history

Name _____ Age _____ Date of last exam _____

Former Dentist _____ Date of last dental x-rays _____

Reason for today's visit _____

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

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

| | | |
|---|---|---|
| ☐ Bad breath | ☐ Grinding teeth | ☐ Sensitivity to heat |
| ☐ Bleeding gums | ☐ Loose teeth or broken fillings | ☐ Sensitivity to sweets |
| ☐ Clicking or popping jaw | ☐ Periodontal treatment | ☐ Sensitivity when biting |
| ☐ Food collection between teeth | ☐ Sensitivity to cold | ☐ 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

Check (√) if you have had any of the following:

| | | | |
|---|---|---|---|
| ☐ AIDS | ☐ Congenital Heart Lesions | ☐ Hepatitis | ☐ Rheumatic Fever |
| ☐ Anemia | ☐ Cortisone Treatments | ☐ Hernia Repair | ☐ Scarlet Fever |
| ☐ Arthritis, Rheumatism | ☐ Cough, Persistent | ☐ High Blood Pressure | ☐ Shortness of Breath |
| ☐ Artificial Heart Valves | ☐ Cough up Blood | ☐ HIV positive | ☐ Skin Rash |
| ☐ Artificial Joints | ☐ Diabetes | ☐ Jaw Pain | ☐ Stroke |
| ☐ Asthma | ☐ Epilepsy | ☐ Kidney Disease | ☐ Swelling of Feet or Ankles |
| ☐ Back Problems | ☐ Fainting | ☐ Liver Disease | ☐ Thyroid Problems |
| ☐ Bleeding Abnormally | ☐ Glaucoma | ☐ Mitral Valve Prolapse | ☐ Tobacco Habit |
| ☐ Blood Disease | ☐ Headaches | ☐ Nervous Problems | ☐ Tonsillitis |
| ☐ Cancer | ☐ Heart Murmur | ☐ Pacemaker | ☐ Tuberculosis |
| ☐ Chemical Dependency | ☐ Heart Problems | ☐ Psychiatric Care | ☐ Ulcer |
| ☐ Chemotherapy | Describe _____ | ☐ Radiation Treatment | ☐ Venereal Disease |
| ☐ Circulatory Problems | ☐ Hemophilia | ☐ Respiratory Disease | |

Have you ever taken any of these medications?

| | | | | |
|---|---|---|---|---|
| **Diet Medications:** | ☐ Dexfenfluramine | ☐ Fen-phen | ☐ Pondimin | ☐Redux |
| **Blood Thinners:** | ☐ Coumadin | ☐ Warfarin | | |
| **Other:** | ☐ Levoxyl | ☐ Synthroid | | |

## Certification and assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____

Name of Insurance Company(ies)

And assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or for one year from the date signed below.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Date