DENTAL HISTORY

Reason for Today's Visit _____
Date of last dental x-rays _____

Check (✓) if you have any of the following:
❑ Bad Breath ❑ Grinding teeth ❑ Food collection between teeth
❑ Bleeding gums ❑ Loose teeth or broken fillings ❑ Sores or growths in your mouth
❑ Clicking or popping jaw ❑ Periodontal treatment ❑ Sensitivity

Please check YES or NO in response to the following questions:
Are any of your teeth loose, or are you concerned about any teeth loosening: ___Yes ___No
Do you currently have any dental implants, dentures, or partials? ____Yes ____No
Have you ever had any complications following dental treatment? ___Yes ____No
Do your gums bleed when you brush or floss? ___Yes ___No

MEDICAL HISTORY

Physician's Name (or Facility Name) _____
Phone _____
Have you had any serious illnesses or operations? ❑N ❑Y
Describe: _____

Women: Are you pregnant? ❑N ❑Y Nursing? ❑N ❑Y Taking Birth Control Pills? ❑N ❑Y

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

_____ ❑Artificial joints
_____ ❑Kidney disease
_____ ❑Rheumatic/Scarlet Fever
_____ ❑Heart murmur
_____ ❑ Heart pacemaker
_____ ❑Artificial heart valve
_____ ❑Other heart condition
Describe _____

_____ ❑Liver disease
_____ ❑Chemical dependency
_____ ❑Thyroid disease
_____ ❑Glaucoma
_____ ❑Heart attack
_____ ❑Cancer
_____ ❑Chemotherapy/Radiation

_____ ❑Hepatitis
_____ ❑Tuberculosis
_____ ❑Blood transfusion
_____ ❑AIDS/HIV positive
_____ ❑Stroke
_____ ❑Hay fever
_____ ❑Herpes

_____ ❑Hemophilia
_____ ❑Latex allergy
_____ ❑ Diabetes
_____ ❑Jaw pain
_____ ❑Sinus trouble
_____ ❑Fainting/dizzy spells

_____ ❑Arthritis, Rheumatism
_____ ❑cortisone treatments
_____ ❑Ulcers
_____ ❑Anemia/Sickle Cell Disease
_____ ❑Angina Pectoris
_____ ❑Emphysema

_____ ❑Psychiatric care
_____ ❑Tobacco habit
_____ ❑High Blood Pressure
_____ ❑Asthma
_____ ❑Epilepsy/seizures

List all medications you are currently taking:
_____
_____
_____

List drug allergies:
_____
_____
_____

Medical History Update (for office use)

Date	Comments	Signature
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____

AUTHORIZATION & RELEASE

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes in my medical status.
I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all my insurance submissions. I hereby authorize the dentist to release all information necessary to secure the payment of benefits.
I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment.

_____ **Date**_____
Signature of Patient, Parent or Guardian