## *Dental Health History*

Reason for today's visit_____
Previous Dentist_____
Address_____Phone_____
Date of last dental Care_____Last dental X-rays_____

Please check (✓) if you have had trouble with any of the following

| | | |
|---|---|---|
| ☐ 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 Collecting in teeth | ☐ Sensitivity to Cold | ☐ Sores in your mouth |

How often do you floss?_____How often do you brush?_____

## *Medical History*

Physicians Name_____Date of last visit_____
Previous Hospitalizations, illness, or operations (please describe and give approximate date) _____
_____
Have you ever had a blood transfusion? ☐Yes ☐No If yes, please give approximate date_____
Women: Are you Pregnant? ☐Yes ☐No Nursing? ☐Yes ☐No Taking Birth control Pills? ☐Yes ☐No
Please check (✓) if you have or have had any of the following:

| | | | |
|---|---|---|---|
| ☐AIDS | ☐Stroke | ☐Hepatitis | ☐Anemia |
| ☐HIV Positive | ☐High Blood Pressure | ☐Scarlet Fever | ☐Jaw Pain |
| ☐Arthritis, Rheumatism | ☐Shortness of Breath | ☐Rheumatic Fever | ☐Fainting |
| ☐Artificial Heart Valves | ☐Coughs up Blood | ☐Diabetes | ☐Skin Rash |
| ☐Artificial Joints | ☐Cough, Persistent | ☐Cancer | ☐Epilepsy |
| ☐Mitral Valve Prolapse | ☐Swelling of Feet or Ankles | ☐Glaucoma | ☐Tobacco Habit |
| ☐Heart Murmur | ☐Thyroid Problems | ☐Headaches | ☐Nervous Problems |
| ☐Heart Problems: Describe_____ | | ☐Tonsillitis | ☐Chemical Dependence |
| ☐Pace Maker | ☐Psychiatric Care | ☐Ulcer | ☐Venereal Disease |
| ☐Tuberculosis | ☐Chemotherapy | ☐Hemophilia | ☐Kidney Disease |
| ☐Circulatory Problems | ☐Cortisone Treatments | ☐Back Problems | ☐Blood Disease |
| ☐Radiation treatment | ☐Liver Disease | ☐Asthma | ☐Respiratory disease |

Please list any medications you are currently taking_____
Please list any allergies (including Drug Allergies)_____

## *Authorization*

I have reviewed this questionnaire and answered its questions accurately to the best of my knowledge. I understand that the answers I have provided will be used by the dentist to determine appropriate dental treatment, and I agree to notify the dentist if any change in my health status should occur.

I authorize the dentist to release all information necessary to secure payment of benefits. I authorize my insurance company to pay directly to the dentist or dental group, insurance benefits otherwise payable to me. I authorize use of this payment of all services rendered on my behalf. I authorize use of this signature on all my insurance submissions, release of information to insurance companies and copy of this authorization may be used in the place of the original.

I authorize the above named dentist 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 for said treatment or in an emergency situation.

***Signature*** _____ ***Date*** _____

***Payment is due in full at time of treatment, unless prior arrangements have been approved.***