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## DENTAL INFORMATION

Reason for today's visit:  Exam  Emergency  Consultation  
 Are you in pain?  No  Yes How Long? \_\_\_\_\_  
 Please indicate  any of the following problems:  
 Discomfort, clicking or popping in jaw.  Lost/Broken Filling(s)  Stained teeth  
 Red, swollen or bleeding gums.  Teeth grinding  Locking Jaw  
 Sensitive tooth, teeth or gums.  Ringing in Ears  Bad breath  
 Blisters/Sores in or around the mouth.  Broken/Chipped tooth  
 Other: \_\_\_\_\_  
 Do you require pre-medication?  Yes  No  Don't know  
 Previous Dentist: \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Name Phone#  
 Last Dental exam: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Last Dental X-rays: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Times a day you brush? \_\_\_\_\_ Times a week you floss? \_\_\_\_\_  
 What type of tooth brush bristles do you use?  Soft  Medium  Hard  
 How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

## MEDICAL HISTORY

**What medications are you taking?**  Nerve pills  Pain killers (including aspirin)  Muscle relaxers  
 Stimulants  Blood Thinners  Tranquilizers  Insulin  Meds for Osteoporosis  
 Other(s), please list: \_\_\_\_\_  
**Do you have or have you had any of the following diseases, medical conditions or procedures?**  

<b>Y N</b> Heart Attack / Stroke	<b>Y N</b> Thyroid Problems	<b>Y N</b> Cancer/Tumors	<b>Y N</b> Cosmetic Surgery
<b>Y N</b> Heart Surg./Pacemaker	<b>Y N</b> Kidney Problems	<b>Y N</b> Shingles	<b>Y N</b> Xray or Cobalt Treatment
<b>Y N</b> Heart Murmur	<b>Y N</b> Liver Problems	<b>Y N</b> Hepatitis	<b>Y N</b> Chemotherapy
<b>Y N</b> Rheumatic Fever	<b>Y N</b> Respiratory Problems	<b>Y N</b> HIV+/AIDS/ARC	<b>Y N</b> Asthma
<b>Y N</b> Mitral Valve Prolapse	<b>Y N</b> Sinus Problems	<b>Y N</b> Arthritis/ Rheumatism	<b>Y N</b> Difficulty Breathing
<b>Y N</b> Artificial Valves	<b>Y N</b> Stomach Problems/Ulcers	<b>Y N</b> Artificial Bones/Joints	<b>Y N</b> Diabetes/Hypoglycemia
<b>Y N</b> Heart Disease	<b>Y N</b> Psychiatric Problems	<b>Y N</b> Emphysema	<b>Y N</b> Leukemia
<b>Y N</b> Congenital Heart Defect	<b>Y N</b> Venereal Disease	<b>Y N</b> Fainting/Seizures/Epilepsy	<b>Y N</b> Anemia
<b>Y N</b> Chest Pains	<b>Y N</b> Alcohol/Drug Abuse	<b>Y N</b> Severe/Frequent Headaches	<b>Y N</b> High/Low Blood Pressure
<b>Y N</b> Scarlet Fever	<b>Y N</b> Tuberculosis TB	<b>Y N</b> Frequent Neck Pain	<b>Y N</b> Bleeding Problems
<b>Y N</b> Nervousness	<b>Y N</b> Jaw Problems TMJ/TMD	<b>Y N</b> Back Problems	<b>Y N</b> Glaucoma

  
 Please list any other surgeries or medical conditions you have or ever had: \_\_\_\_\_  
 Are you allergic to any of the following?  Latex  Penicillin / Amoxicillin  Tetracycline  Aspirin  
 Dental Anesthetics  Foods: \_\_\_\_\_  Others: \_\_\_\_\_  
 Do you use tobacco?  No  Yes/How used? \_\_\_\_\_ How much? \_\_\_\_\_ How long? \_\_\_\_\_  
 Please rate your general health from 1-10: \_\_\_\_\_ Do you wear contact lenses?  Yes  No  
 Have you ever taken the drug Phen-fen and or Redux?  Yes  No  
**For women:** Are you taking Birth Control pills?  Yes  No How many children have you had? \_\_\_\_\_  
 Are you Pregnant?  No  Yes/How long? \_\_\_\_\_ Are you nursing?  Yes  No



PLEASE RECYCLE SO THAT WE MAY PRESERVE HEALTH OF OUR PLANET.

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
 Adult Patient  Parent or Guardian  Spouse

### UPDATE (OFFICE USE)

Initials \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Initials Date

Comments \_\_\_\_\_

Initials \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Initials Date

Comments \_\_\_\_\_

Initials \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Initials Date

Comments \_\_\_\_\_