

Dental History

Patient Name _____ Medical Alert _____

Welcome! So that we may provide you with the best possible care, please complete both sides of this dental/medical history form. All information is completely confidential.

Home Address: _____

Hm #: (____) _____ Wk#: (____) _____ Cell: _____

I prefer to be called: _____ Birthdate: _____ Age: _____ S.S.#: _____

Male__ Female__ ___Single ___Married ___Divorced ___Widowed ___Separated

Employer: _____ Employer's Address: _____

How long there? _____ Occupation: _____

Whom may we Thank for referring you? _____

Spouse's Name: _____ Birthdate: _____

S.S.#: _____

Employer: _____ Wk#: (____) _____ Ext: _____

Person responsible for account? _____ Hm#: (____) _____ Wk#: (____) _____

Billing Address: _____ Relationship: _____

Do you have Dental Insurance? Yes No

Name of insured _____ Group # _____

S.S.#: _____

Employer: _____

Name of Ins. _____ Address of Ins. _____

Do you have any dental problems now? Yes__ No__

If yes, please describe: _____

What is the reason for your visit today? _____

Date of Last Dental Visit. _____ Last Dental Cleaning. _____ Last Full Mouth X-rays. _____

What was done at your last dental visit? _____

Previous Dentist's Name. _____

Reason for leaving previous dentist? _____

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

Do you drink well water or bottled water? _____

Are any of your teeth sensitive to:

Hot or Cold? Sweets? Yes No

Biting or chewing? Yes No

Have you noticed any mouth odors or bad taste? Yes No

Do you frequently get cold sores, blisters or
any other oral lesions? Yes No

Do your gums bleed or hurt? Yes No

Have your parents experienced gum disease or tooth loss? Yes No

Have you noticed any loose teeth or change in your bite? Yes No

Does food tend to become caught in between your teeth?
if yes, where? _____ Yes No

Do you:

Clench or grid your teeth while awake or asleep? Yes No

Bite your lips or cheeks regularly? Yes No

Mouth breathe while awake or asleep? Yes No

Have tired jaws, especially in the morning? Yes No

Smoke or chew tobacco? Yes No

Have you ever had:

Oral surgery/Orthodontic treatment? Yes No

Periodontal treatment? Yes No

Your teeth ground or the bite adjusted? Yes No

A bite plate or mouth guard? Yes No

A serious injury to the mouth or head? Yes No

If so, please describe, including cause: _____

Clicking or popping of the jaw? Yes No

Pain? (joint, ear, side of face) Yes No

Difficulty in opening or closing the mouth? Yes No

Difficulty in chewing on either side of mouth? Yes No

Headaches, neckaches, or shoulder aches? Yes No

Sore Muscles? (neck, shoulders) Yes No

Are you satisfied with the appearance
of your teeth? Yes No

Would you like to keep your teeth all
of your life? Yes No

Have you ever had an upsetting
dental experience? Yes No

Do you feel nervous about having dental treatment? Yes No
If so, what is your biggest concern? _____

Health History

Physician's name _____

Phone number _____

1. Have you been hospitalized in the past two years? Yes No
2. Have you been under the care of a medical doctor during the past two years? Yes No
3. Are you presently taking any prescription medications? List _____

4. Are you allergic or have you reacted adversely to any of the following?

Aspirin	Nitrous Oxide	Valium	Local Anesthetic
Darvon	Erythromycin	Scopolamine	(Novocaine or Xylocaine)
Codeine	Tetracycline	Penicillin	Sleeping Pills
Demerol	Percodan	Other Antibiotics	(Nembutal/Seconal)
Sulfa	Latex		

Other _____

5. Have you ever had any excessive bleeding requiring special treatment? Yes No
6. Please indicate whether or not you have previously had or have any of the following:

Persistent Cough	Yes	No	Heart Failure	Yes	No	Epilepsy	Yes	No
A.I.D.S.	Yes	No	Heart Disease or Attack	Yes	No	Hemophillia	Yes	No
Immune Deficiency Disease	Yes	No	High Blood Pressure	Yes	No	Asthma	Yes	No
Hepatitis	Yes	No	Heart Murmur	Yes	No	Hay Fever	Yes	No
Liver Disease/Jaundice	Yes	No	Rheumatic Fever/Scarlet Fever	Yes	No	Sinus Trouble	Yes	No
Tuberculosis (TB)	Yes	No	Congenital Heart Defect	Yes	No	Allergies or Hives	Yes	No
Blood Transfusions	Yes	No	Artificial Heart Valve	Yes	No	Diabetes	Yes	No
Polio	Yes	No	Heart Pacemaker	Yes	No	Arthritis	Yes	No
Prolonged Bleeding	Yes	No	Artificial Joints (Hip, Knee)	Yes	No	Rheumatism	Yes	No
Venereal Disease	Yes	No	Anemia	Yes	No	Thyroid Disease	Yes	No
Cold Sores/ Fever Blisters	Yes	No	Stroke	Yes	No	Cancer /Chemotherapy	Yes	No
Kidney Trouble	Yes	No	Organ Transplant	Yes	No	Emphysema	Yes	No
Fainting or Dizzy Spells	Yes	No	Mitral Valve Prolapse	Yes	No	Pain in Jaw Joints	Yes	No
Nervousness	Yes	No				Radiation/ Cobalt Treatment	Yes	No
Drug Dependency	Yes	No				Glaucoma	Yes	No
Psychiatric Treatment	Yes	No				Ulcers	Yes	No

7. Are you taking, or have you taken any diet drugs? Yes No Phen/Fen or Redux

8. Do you have any disease, problem, or condition not listed? Yes No

9. If yes, please explain. _____

10. Are you pregnant? Yes No If yes, what month? _____ Are you practicing birth control? Yes No

To the best of my knowledge, all of the preceding answers are true and correct. I will notify the doctor of any changes in my health or medication.

Patient Name: _____ Date: _____

Payment is due in full at the time of treatment

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company. In the event that payment for dental services is not made within ninety(90) days of service, then interest at the rate of 1 1/2% per month may be added to the past due balance.

Signature _____ Date: _____