Dental History

What would you like us to do today?_____

Are you in dental discomfort today? _____

Former Dentist _____ Address _____ Phone _____

Dentist's Email _____

Date of last dental care _____ Date of last X-rays_____

Check Y for yes or N for no if you have or have not had the following:

☐Y ☐N Bad breath	☐Y ☐N Sensitivity to sweets	☐Y ☐N Sensitivity to cold	☐Y ☐N Loose teeth or broken fillings
☐Y ☐N Food collection between teeth	☐Y ☐N Bleeding gums	☐Y ☐N Sensitivity when biting	☐Y ☐N Sensitivity to hot
☐Y ☐N Periodontal treatment	☐Y ☐N Grinding or clenching teeth	☐Y ☐N Clicking or popping jaw	☐Y ☐N Sores or growths in mouth

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

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐Y ☐N

Medical History

Physician's name _____ Address _____ Phone _____

Physician's Email _____

Date of last visit _____☐Y ☐N Have you had any serious illnesses or operations? If yes, describe_____

☐Y ☐N Are you currently under physician care? If yes, describe _____

☐Y ☐N Have you ever had a blood transfusion? If yes, give approximate date(s) _____

☐Y ☐N Have you ever taken Fen-Phen/Redux?

☐Y ☐N Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?
Date: _____ If yes, have you had any complications?_____

Women: ☐Y ☐N Are you pregnant? ☐Y ☐N Nursing? ☐Y ☐N Taking birth control pills?

Check Y for yes or N for no if you have or have not had the following:

☐Y ☐N AIDS/HIV Positive	☐Y ☐N Cough, persistent	☐Y ☐N High blood pressure	☐Y ☐N Scarlet fever
☐Y ☐N Anaphylaxis	☐Y ☐N Cough up blood	☐Y ☐N Jaw pain	☐Y ☐N Shingles
☐Y ☐N Anemia	☐Y ☐N Diabetes	☐Y ☐N Joint Replacement	☐Y ☐N Shortness of breath
☐Y ☐N Arthritis, Rheumatism	☐Y ☐N Epilepsy	☐Y ☐N Kidney disease or malfunction	☐Y ☐N Skin rash
☐Y ☐N Artificial heart valves	☐Y ☐N Fainting	☐Y ☐N Liver disease	☐Y ☐N Spina Bifida
☐Y ☐N Artificial joints	☐Y ☐N Food allergies	☐Y ☐N Material allergies	☐Y ☐N Stroke
☐Y ☐N Asthma	☐Y ☐N Glaucoma	(latex, wool, metal, chemicals)	☐Y ☐N Surgical implant
☐Y ☐N Atopic (allergy prone)	☐Y ☐N Headaches	☐Y ☐N Mitral valve prolapse	☐Y ☐N Swelling of feet or ankles
☐Y ☐N Back problems	☐Y ☐N Heart murmur	☐Y ☐N Nervous problems	☐Y ☐N Thyroid disease or
☐Y ☐N Blood disease	☐Y ☐N Heart problems	☐Y ☐N Pacemaker/Heart surgery	malfunction
☐Y ☐N Cancer	Describe _____	☐Y ☐N Psychiatric care	☐Y ☐N Tobacco habit
☐Y ☐N Chemical dependency	☐Y ☐N Hemophilia/	☐Y ☐N Rapid weight gain or loss	☐Y ☐N Tonsillitis
☐Y ☐N Chemotherapy	Abnormal bleeding	☐Y ☐N Radiation treatment	☐Y ☐N Tuberculosis
☐Y ☐N Circulatory problems	☐Y ☐N Herpes	☐Y ☐N Respiratory disease	☐Y ☐N Ulcer/Colitis
☐Y ☐N Cortisone treatments	☐Y ☐N Hepatitis	☐Y ☐N Rheumatic fever	☐Y ☐N Venereal disease

☐Y ☐N Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atolvia®, Boniva®, Reclast®, Prolia®) for osteoporosis or Paget's Disease?

☐Y ☐N Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? Date Treatment began: _____

List MEDICATIONS you are currently taking, if any:

_____

_____

List DRUG ALLERGIES, if any:

_____

_____

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

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