Patient Name: _____ **Date: _____**

DENTAL HISTORY

Date of last dental care _____ Last dental cleaning _____ Last full mouth x-rays _____

What was done at your last dental visit? _____

Check off, if you have had problems with any of the following:

- ☐ Smile
- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Periodontal/Gums
- ☐ Clicking or popping jaw
- ☐ Loose teeth or broken fillings
- ☐ Food collection between teeth
- ☐ Grinding teeth (while awake or asleep)
- ☐ Sensitivity to sweets, cold or hot
- ☐ Sensitivity on biting or chewing
- ☐ Sores or growth in your mouth
- ☐ Do you floss? Yes___ No___

Are you satisfied with your teeth's appearance? ☐ Yes ☐ No

If no, please explain: _____

MEDICAL HISTORY

Medical Physician's Name _____ Phone # _____Last Medical Evaluation: _____

Pharmacy name and Number _____

Are you currently under a physician's care? ☐ Yes ☐ No

If yes, describe _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No

If yes, describe _____

Do you take antibiotic prophylaxis before dental procedures? ☐ Yes ☐ No

Have you ever taken any medications for Osteoporosis? ☐ Yes ☐ No.

If yes, describe _____

Women: Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check off if you have had problems with any of the following:

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial heart valves
- ☐ Artificial joints (hip, knee)
- ☐ Asthma
- ☐ Back problems
- ☐ Blood disease
- ☐ Blood pressure (high or low)
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Chemotherapy
- ☐ Circulatory problems
- ☐ Cortisone treatment
- ☐ Cough, Persistent
- ☐ Cough up blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches (regularly)
- ☐ Heart murmur
- ☐ Heart problems

describe _____

- ☐ Autistic
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ HIV Positive
- ☐ Jaw Pain
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Mitral valve prolapsed
- ☐ Nervous problems
- ☐ Pacemaker
- ☐ Psychiatric care
- ☐ Radiation treatment
- ☐ Respiratory (lung) disease
- ☐ Anxiety
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of breath
- ☐ Skin rash
- ☐ Stroke
- ☐ Swelling of feet/ankles
- ☐ Thyroid problems
- ☐ Tobacco habit
- ☐ Tonsillitis
- ☐ Tuberculosis (TB)
- ☐ Ulcer
- ☐ Venereal disease

MEDICATIONS (please list medications you are currently taking):

_____

_____

ALLERGIES:

_____

_____

AUTHORIZATION

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, which may release such information to you. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for the 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 my insurance.
I consent to the Dental practice using my cell phone number to call or text regarding appointments, dental treatment, insurance, and my account.

***Signature** _____ Date _____

Dr.'s Signature _____ Date _____

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