

CONTACT NUMBERS

Home: _____ Work: _____

Cell: _____ e-mail: _____

Best time and place to reach you: _____

Pharmacy: _____ Phone: _____

In case of emergency, contact (Specify someone who does not live with you.)

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

PATIENT'S DENTAL HISTORY

Former Dentist: _____

City/State: _____ Last Visit Date: _____

Date of last dental x-rays: _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Bad Breath	Y__ N__	Lip or cheek biting	Y__ N__
Bleeding Gums	Y__ N__	Loose teeth or broken fillings	Y__ N__
Blisters (Lips/Mouth)	Y__ N__	Mouth breathing	Y__ N__
Burning Sensation on tongue	Y__ N__	Mouth pain, brushing	Y__ N__
Chew on one side of mouth	Y__ N__	Orthodontic treatment	Y__ N__
Cigarette, pipe or Cigar smoking	Y__ N__	Pain around ear	Y__ N__
Clicking or popping jaw	Y__ N__	Periodontal treatment	Y__ N__
Dry Mouth	Y__ N__	Sensitivity to cold	Y__ N__
Fingernail Biting	Y__ N__	Sensitivity to heat	Y__ N__
Food collection between the teeth	Y__ N__	Sensitivity to sweets	Y__ N__
Grinding teeth	Y__ N__	Sensitivity to biting	Y__ N__
Jaw pain or tenderness	Y__ N__	Sore or growths in your mouth	Y__ N__
How often do you floss? _____		Swollen or tender gums	Y__ N__
		Tobacco chewing	Y__ N__
		How often do you brush? _____	

PATIENT'S MEDICAL HISTORY

Physician's Name _____

Date of Last Physical _____

Have you ever responded adversely to medical or dental treatment?

___ Yes ___ No If yes, please describe:

Do you have any drug allergies or have you ever had an adverse reaction to any medication or anesthesia? ___ No ___ Yes

If so, what? _____

If you are taking any medication at this time, please list: _____

If you are currently under the care of a physician, please list the condition (s) being treated: _____

Have you been advised by a physician to pre-medicate prior to dental appointments? ___ Yes ___ No

(Women) Do you suspect you may be pregnant? ___ Yes ___ No
Due date: _____ Are you nursing? ___ Yes ___ No
Taking birth control pills? ___ Yes ___ No

If patient is a child, what is his/her weight? _____

Have you ever had any of the following? (Check all boxes that apply.)

- | | |
|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Hepatitis, Jaundice, or Liver Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hernia Repair |
| <input type="checkbox"/> Artificial Heart Valves or Joints, Screws, etc. | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Bleeding Abnormality | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Nervous Problems |
| Specifically: _____ | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Chronic Diarrhea | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Recent Weight Loss |
| <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Special Diet |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Swollen Neck Glands |
| | <input type="checkbox"/> Ulcer |
| | <input type="checkbox"/> Venereal Disease |

CERTIFICATION

To the best of my knowledge, the information provided on this form is complete and correct.

Signature of Patient

MINOR/DEPENDENT CHILD CONSENT

I am the parent, guardian or personal representative of _____ and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the minor/dependent child named above, including but not limited to x-rays and administration of anesthetics as deemed advisable by the doctor, whether or not I am present when treatment is rendered.

Signature of Parent, Guardian or Personal Representative