

DENTAL HISTORY

Date: _____

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? _____

How often do you have dental examinations? _____

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

What other dental aids do you use? (automatic tooth brush, toothpick, water pik, etc) _____

Do you have any dental problems now? Yes No
If yes, please describe: _____

Are any of your teeth sensitive to:

- Hot or Cold? Yes No
- Sweets? Yes No
- Biting or Chewing? Yes No
- Have you noticed any mouth odors or bad tastes? 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? Yes No
- If yes, where? _____

Do you:

- Clench or grind your teeth while awake or asleep? Yes No
- Bite your lips or cheeks regularly? Yes No
- Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) Yes No
- Mouth breathe while awake or asleep? Yes No
- Have tired jaws, especially in the morning? Yes No
- Smoke/chew tobacco? Yes No

Have you ever had:

- Orthodontic treatment? Yes No

- Oral Surgery? 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 yes, please describe, including cause _____

Have you experienced:

- Clicking or popping of the jaw? Yes No
- Pain? (joint, ear, side of face) Yes No
- Difficulty in chewing on either side of the mouth? Yes No
- Headaches, neckaches, or shoulder aches? Yes No
- Are you satisfied with your teeth's appearance?** Yes No
- Would you like to keep all of your teeth all of your life? Yes No
- Would you like your teeth whiter? Yes No
- Do you feel nervous about having dental treatment? Yes No
- If yes, what is your biggest concern? _____

- Have you ever had an upsetting dental experience? Yes No
- If yes, please describe _____

1. Have you been under the care of a medical doctor during the past two years? Yes No
If yes, for what? _____

Physician's Name _____ Phone _____
Address _____ City _____ State _____ Zip _____

2. Have you taken any medication or drugs during the past two years? Yes No
3. Are you taking medication, drugs, or pills now? Yes No
If yes, please list name and dosage _____

4. Have you ever taken prescription medications for weight loss (diet pills) Yes No
If yes, did you take any of the following: Yes No Fen-Phen (Fenfluramine-Phenpermine)
Yes No Pondimin (Fenfluramine)
Yes No Redux (Dexfenfluramine)

If yes to any of the above, did you have a medical exam for heart issues? Yes No

MEDICAL HISTORY

Patient Name _____

5. Are you aware of having an allergic (or adverse) reaction to any medication or substance..... Yes No
If yes, please list _____
6. Have you been a patient in the hospital during the past five years..... Yes No
7. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.
- | | | |
|---|---|---|
| Heart (Surgery, Disease, Attack) Yes No | Diabetes..... Yes No | A.I.D.S..... Yes No |
| Chest Pain..... Yes No | Thyroid Problems..... Yes No | H.I.V. Positive..... Yes No |
| Congenital Heart Disease..... Yes No | Glaucoma..... Yes No | Blood Transfusion..... Yes No |
| Heart Murmur..... Yes No | Emphysema..... Yes No | Hemophilia..... Yes No |
| High Blood Pressure..... Yes No | Chronic Cough..... Yes No | Sickle Cell Disease..... Yes No |
| Mitral Valve Prolapse..... Yes No | Tuberculosis..... Yes No | Bruise Easily..... Yes No |
| Artificial Heart Valve..... Yes No | Asthma..... Yes No | Liver Disease..... Yes No |
| Heart Pacemaker..... Yes No | Latex Sensitivity..... Yes No | Neurological Disorders..... Yes No |
| Rheumatic Fever..... Yes No | Allergies or Hives..... Yes No | Epilepsy or Seizures..... Yes No |
| Arthritis/Rheumatism..... Yes No | Sinus Trouble..... Yes No | Fainting or Dizzy Spells..... Yes No |
| Swollen Ankles..... Yes No | Radiation Therapy..... Yes No | Psychiatric/Psychological Care.. Yes No |
| Stroke..... Yes No | Chemotheramy..... Yes No | |
| Artificial Joints (hip, knee, etc.)... Yes No | Tumors..... Yes No | |
| Other Prosthesis or Implants..... Yes No | Hepatitis A (infectious) B (serum) Yes No | |
| Kidney Trouble..... Yes No | Venereal Disease..... Yes No | |
| Ulcers..... Yes No | | |
8. Do you use more than two pillows to sleep..... Yes No
9. Have you lost or gained more than 10 pounds in the past year..... Yes No
10. Do you have or have had any disease, condition, or problem not listed..... Yes No
If yes, please list _____

11. Women: Are you: **Pregnant?** Yes, ___ Months No **Nursing?** Yes No **Taking birth control pills?** Yes No

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, who may release such information to you. I will notify the doctor of change in my health or medication.

Patient/Guardian Signature _____ Date _____

CONSENT OF TREATMENT

- I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.
- Upon such diagnosis, I authorize doctor to preform all recommended treatment mutually agreed upon by me and to emply such assistance as required to provide proper care.
- I agree to the use of anesthetics, sedatives and other medication as necessary, I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for the complete recital of any possible complications.
- I agree that I will give 48 hours notice, in the event that I find it necessary to cancel an appointment. If 48 hours notice is not given I understand that a cancellation fee of \$100.00 will be applied to my account.
- I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1-1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature _____ Date _____

Parent/ Responsible Party's Signature _____ Relationship to Patient _____

