

**MEDICAL HISTORY (cont.)**

- 13. Are you taking any other medications? .....  
If so, what are they? \_\_\_\_\_
- 14. Are you allergic to, or have you reacted adversely to:
  - A. Local Anesthetic(s)? .....
  - B. Penicillin or other antibiotics? .....
  - C. Sulfa drugs? .....
  - D. Barbiturates, sedatives or sleeping pills? .....
  - E. Aspirin? .....
  - F. Iodine? .....
  - G. Codeine or other narcotics? .....
  - H. Other? .....
- 15. Do you have any disease, condition, or problem not listed above that you think we should know about? \_\_\_\_\_
- 16. Are you employed in a position which exposes you regularly to x-rays or any other ionizing radiation? .....
- 17. Are you wearing, or do you wear, contact lenses? .....
- 18. Do you smoke? How much per day? \_\_\_\_\_
- 19. Do you use other tobacco products? How often? \_\_\_\_\_
- 20. Have you been treated for drug or alcohol dependency? .....
- 21. Have you had any joint replacement surgeries? .....
- 22. Has a physician recommended antibiotic pre-med for any dental treatment due to any other condition? .....

DATE / /	DATE / /
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**DENTAL HISTORY**

- 1. What is your chief dental complaint? \_\_\_\_\_
- 2. Are you experiencing any discomfort or pain at this time? .....
- 3. Are you satisfied with the appearance of your teeth? .....
- 4. Are you able to eat and chew foods satisfactorily? .....
- 5. Do you have headaches, earaches, or neck pain? .....
- 6. Do you frequently experience sinus problems? .....
- 7. Have you had any serious trouble associated with any previous dental treatment? .....  
If yes, please explain \_\_\_\_\_
- 8. When did you last see a Dentist for an exam? \_\_\_\_\_ cleaning? \_\_\_\_\_

Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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**WOMEN**

- 1. Are you pregnant? .....
- 2. Are you nursing? .....
- 3. Do you have any problems associated with your menstrual period? .....
- 4. Are you taking oral contraceptives or hormonal therapy? .....

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**RESPONSIBILITY AND CONSENT STATEMENT**

I hereby authorize and request the performance of dental services for myself or for

I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by his supervised staff for diagnostic purposes or dental treatment. These records may include study models, photographs, x-rays, and blood studies and may be used for teaching purposes.

I understand and acknowledge that I am financially responsible for the services provided for myself or the above named, regardless of insurance coverage. My signature below constitutes assignment of insurance benefits to the office of Dr. Colquitt for services rendered and a photocopy shall be as valid as the original.

Treatment plans involving extended credit circumstances may have a credit check done on my credit rating. I also understand that the treatment estimate presented to me is only an estimate. Occasionally the need may arise to modify treatment. In such a case, I will be informed of the need for additional treatment, and fee.

Signature of Patient \_\_\_\_\_

Signature of Dentist \_\_\_\_\_ Date \_\_\_\_\_