DENTAL INFORMATION

Reason for today's visit: □ Exam □ Emergency □ Consultation
Are you in pain? □ No □ Yes How Long? _____
Please indicate (√) any of the following problems:
□ Discomfort, clicking or popping in jaw. □ Lost/Broken Filling(s) □ Stained teeth
□ Red, swollen or bleeding gums. □Teeth grinding □ Locking Jaw
□ Sensitive tooth, teeth or gums. □ Ringing in ears □ Bad breath
□ Blisters/Sores in or around the mouth. □ Broken/Chipped tooth
□ Other: _____
Do you require per-medication? □Yes □No □Don't know
Previous Dentist: _____ Phone #: _____

Last Dental exam: ___/___/___ Last Dental X-rays: ___/___/___

Times a day you brush? _____ Times a week you floss? _____
How would you rate your smile? (WORST) 1 2 3 4 5 6 7 8 9 10 (BEST)

MEDICATION LIST

Please list all medications you are currently taking:

MED DOSAGE REASON

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

MEDICAL HISTORY

Have you ever taken: Bisphosphonates (ex. Aredia/Fosamax) □ Yes □ No
Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack / Stroke	**Y N** Thyroid Problems	**Y N** Cancer / Tumors	**Y N** Cosmetic Surgery
Y N Heart Surg. / Pacemaker	**Y N** Kidney Problems	**Y N** Shingles	**Y N** Radiation Treatment
Y N Heart Murmur	**Y N** Liver Problems	**Y N** Hepatitis (A, B, C)	**Y N** Chemotherapy
Y N Rheumatic Fever	**Y N** Respiratory Problems	**Y N** HIV+ / AIDS / ARC	**Y N** Asthma
Y N Mitral Valve Prolapse	**Y N** Sinus Problems	**Y N** Arthritis/Rheumatism	**Y N** Difficulty Breathing
Y N Artificial Valves	**Y N** Stomach Problems/Ulcers	**Y N** Artificial Bones/Joints	**Y N** Diabetes / Hypoglycemic
Y N Heart Disease	**Y N** Venereal Disease	**Y N** Emphysema	**Y N** Glaucoma
Y N Congenital Heart Defect	**Y N** Chemical Dependency	**Y N** Fainting/Seizure/Epilepsy	**Y N** Anemia
Y N Blood Disease	**Y N** Tuberculosis TB	**Y N** Frequent Neck Pain	**Y N** Scarlet Fever
Y N Blood Thinners	**Y N** Bleeding Problems/Hemophilia	**Y N** Nervousness	**Y N** Jaw Pain TMJ / TMD
Y N Back Problems	**Y N** Severe / Frequent Headaches	**Y N** Gastric Bypass	**Y N** Dialysis

List any other surgeries or medical conditions you have or ever had: _____
_____
Are you allergic to any of the following? □ **Latex** □ **Penicillin/Amox** □**Tetracycline** □ **Aspirin**
□ **Dental Anesthetics/Epinephrine** □ **Foods:** _____ □**Others:** _____
Do you use tobacco? □No □Yes/how used? _____ How much? _____ How long? _____
Please rate your overall general health from 1-10: _____ Do you wear contact lenses? □Yes □No

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account. We require 24 business hours notice for all rescheduled or cancelled appointments
- I have read & understand the privacy policy. I authorize the staff to perform any necessary services needed during diagnosis & treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date _____
□Adult Patient □Parent or Guardian □Spouse