PATIENT NAME____ DATE:______________________________

DENTAL HISTORY

DO YOU HAVE A SPECIFIC DENTAL PROBLEM? ____

PREVIOUS DENTIST ____ DATE OF LAST DENTAL VISIT ______________________________

WHY ARE YOU SWITCHING DENTISTS? ____

CHECK IF YOU HAVE OR HAVE HAD PROBLEMS WITH ANY OF THE FOLLOWING:

__ BAD BREATH	__GRINDING TEETH	__SENSITIVITY TO COLD	__SORES/GROWTHS IN MOUTH
__BLEEDING GUMS	__HOSPITALIZATION	__SENSITIVITY TO HOT	__ SPECIAL DIET
__CLICKING OR POPPING JAW	__LOOSE TEETH OR BROKEN FILLINGS	__SENSITIVITY TO SWEETS	__BAD EXPERIENCE AT DENTIST
__FOOD COLLECTION BETWEEN TEETH	__PERIODONTAL TREATMENT	__SENSITIVITY WHEN BITING	__LOOKS OF YOUR SMILE

HOW OFTEN DO YOU FLOSS? _________________________________ HOW OFTEN DO YOU BRUSH? ______________________________

MEDICAL HISTORY

PHYSICIAN'S NAME ____ DATE OF LAST VISIT ____________________________________

HAVE YOU HAD ANY SERIOUS ILLNESSES OR OPERATIONS? YES__ NO__ IF YES, DESCRIBE_____________________________________

HAVE YOU EVER HAD A SERIOUS INJURY TO YOUR HEAD OR NECK? YES__ NO__ IF YES, DESCRIBE________________________________

(WOMEN) ARE YOU PREGNANT? YES__ NO__ NURSING? YES__ NO__ TAKING BIRTH CONTROL? YES__ NO__

CHECK IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

__ ANEMIA	__CONGENITAL HEART LESIONS	__HEPATITIS	__SCARLET FEVER
__ARTHRITIS, RHEUMATISM	__CORTISONE TREATMENTS	__HERNIA REPAIR	__SHORTNESS OF BREATH
__ARTIFICIAL HEART VALVES	__COUGH, PERSISTANT	__HIGH BLOOD PRESSURE	__SKIN RASH
__ARTIFICIAL JOINTS, PINS, ETC.	__COUGH UP BLOOD	__HIV/AIDS	__STROKE
__ASTHMA	__DIABETES	__JAW PAIN	__SWELLING OF FEET /ANKLES
__BACK PROBLEMS	__EPILEPSY	__KIDNEY DISEASE	__THYROID PROBLEMS
__BLEEDING ABNORMALLY	__FAINTING	__LIVER DISEASE	__TOBACCO HABIT
__BLOOD DISEASE	__GLAUCOMA	__MITRAL VALVE PROLAPSE	__TONSILLITIS
__CANCER	__HEADACHES	__PACEMAKER	__TUBERCULOSIS
__CHEMICAL DEPENDENCY	__HEART MURMUR	__RADIATION TREATMENT	__ULCER
__CHEMOTHERAPY	__HEART PROBLEMS	__RESPIRATORY DISEASE	__VENEREAL DISEASE
__CIRCULATORY PROBLEMS	__HEMOPHILIA	__RHEUMATIC FEVER	__EVER TAKEN FEN-PHEN

LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING:

____

____

____

ALLERGIES:

__ASPIRIN __PENICILLIN __CODEINE __ACRYLIC __METAL __LATEX

OTHERS: ____

____

AUTHORIZATION AND RELEASE

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS COMPLETE AND CORRECT. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM MY DOCTOR IF I, OR MY DEPENDENT, EVER HAVE A CHANGE IN HEALTH. I GRANT THE RIGHT TO THE DENTIST TO RELEASE MY DENTAL/MEDICAL HISTORIES AND OTHER INFORMATION ABOUT MY DENTAL TREATMENT TO THIRD PARTY PAYORS AND/OR OTHER HEALTH PROFESSIONALS BY ANY METHOD, INCLUDING ELECTRONIC TRANSFER.

SIGNATURE: ____ DATE: ___________________________

(PATIENT OR RESPONSIBLE PARTY)

REVIEWED BY DOCTOR______________________________________ **DATE**___________________________

FOR OFFICE USE—MEDICAL UPDATES

DATE	EXCEPTIONS		DATE	EXCEPTIONS	
________	________________________________	NONE___	________	________________________________	NONE___
________	________________________________	NONE___	________	________________________________	NONE___
________	________________________________	NONE___	________	________________________________	NONE___
________	________________________________	NONE___	________	________________________________	NONE___
________	________________________________	NONE___	________	________________________________	NONE___