

PATIENT DENTAL HISTORY

PATIENT'S NAME _____ DATE OF BIRTH _____

REASON FOR THIS VISIT _____

WHEN WAS YOUR LAST DENTAL VISIT _____ WHAT WAS DONE THEN _____

HOW OFTEN DID YOU VISIT THE DENTIST BEFORE THEN _____

PREVIOUS DENTIST (NAME AND LOCATION) _____

HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (X-RAYS) TAKEN WHEN _____ WHERE _____

HOW OFTEN DO YOU BRUSH YOUR TEETH _____ HOW OFTEN DO YOU FLOSS YOUR TEETH _____

IS YOUR DRINKING WATER FLUORIDATED _____

YES NO

YES NO

DO YOUR GUMS BLEED WHILE BRUSHING
OR FLOSSING.....☐ ☐

ARE YOUR TEETH SENSITIVE TO HOT OR COLD
LIQUIDS/FOODS.....☐ ☐

ARE YOUR TEETH SENSITIVE TO SWEET
OR SOUR LIQUIDS/FOODS.....☐ ☐

DO YOU FEEL PAIN TO ANY OF YOUR TEETH.....☐ ☐

DO YOU HAVE ANY SORES OR LUMPS IN OR
NEAR YOUR MOUTH.....☐ ☐

HAVE YOU EVER EXPERIENCED ANY OF THE
FOLLOWING PROBLEMS IN YOUR JAW?

CLICKING.....☐ ☐

PAIN (JOINT, EAR, SIDE OF FACE).....☐ ☐

DIFFICULTY IN OPENING OR CLOSING.....☐ ☐

DIFFICULTY IN CHEWING.....☐ ☐

DO YOU HAVE FREQUENT HEADACHES.....☐ ☐

DO YOU CLENCH OR GRIND YOUR TEETH.....☐ ☐

DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY.....☐ ☐

HAVE YOU NOTICED ANY LOOSENING OF
YOUR TEETH.....☐ ☐

DOES FOOD TEND TO BECOME CAUGHT
BETWEEN YOUR TEETH.....☐ ☐

HAVE YOU EVER HAD PERIODONTAL
TREATMENT (GUMS).....☐ ☐

EVER WORN A BITE PLATE OR OTHER APPLIANCE.....☐ ☐

HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS
IN THE PAST.....☐ ☐

HAVE YOU EVER HAD ANY PROLONGED BLEEDING
FOLLOWING EXTRACTIONS.....☐ ☐

DO YOU WEAR DENTURES OR PARTIALS.....☐ ☐

IF YES, DATE OF PLACEMENT _____

HAVE YOU EVER RECEIVED ORAL HYGIENE
INSTRUCTIONS REGARDING THE CARE OF

YOUR TEETH AND GUMS.....☐ ☐

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE? _____

AUTHORIZATION AND RELEASE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH.

X _____ DATE _____
SIGNATURE OF PATIENT OR PARENT IF MINOR

DOCTOR'S COMMENTS _____

SIGNATURE _____ DATE _____

PATIENT NUMBER _____

PATIENT'S NAME _____ DATE OF BIRTH _____

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATION THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

	YES	NO		YES	NO
1. ARE YOU IN GOOD HEALTH	<input type="checkbox"/>	<input type="checkbox"/>	9. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION.....	<input type="checkbox"/>	<input type="checkbox"/>
2. DATE OF YOUR LAST PHYSICAL EXAM: _____			10. HAVE YOU HAD A RECENT WEIGHT LOSS.....	<input type="checkbox"/>	<input type="checkbox"/>
3. PHYSICIAN'S NAME _____			11. HAVE YOU EVER TAKEN FEN-FEN, REDUX OR PONDIMEN	<input type="checkbox"/>	<input type="checkbox"/>
ADDRESS _____			12. DO YOU USE TOBACCO.....	<input type="checkbox"/>	<input type="checkbox"/>
PHONE NO. _____			13. DO YOU OR HAVE YOU USED CONTROLLED SUBSTANCES.....	<input type="checkbox"/>	<input type="checkbox"/>
4. ARE YOU NOW UNDER THE CARE OF A PHYSICIAN.....	<input type="checkbox"/>	<input type="checkbox"/>	14. ARE YOU WEARING CONTACT LENSES.....	<input type="checkbox"/>	<input type="checkbox"/>
5. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS.....	<input type="checkbox"/>	<input type="checkbox"/>	15. HAVE YOU EVER BEEN TOLD TO TAKE ANTIBIOTICS OR PRE MEDICATION BEFORE SEEING A DENTIST ...	<input type="checkbox"/>	<input type="checkbox"/>
6. ARE YOU TAKING ANY MEDICINES (INCLUDING NON-PRESCRIPTION MEDICINE)	<input type="checkbox"/>	<input type="checkbox"/>			
IF YES, WHAT MEDICINES ARE YOU TAKING _____					

7. HAVE YOU HAD ANY ABNORMAL BLEEDING.....	<input type="checkbox"/>	<input type="checkbox"/>			
8. DO YOU BRUISE EASILY	<input type="checkbox"/>	<input type="checkbox"/>			

WOMEN ONLY:

ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT..... ☐ ☐

ARE YOU NURSING

ARE YOU TAKING BIRTH CONTROL PILLS

	YES	NO		YES	NO
ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:			HIVES OR SKIN RASH	<input type="checkbox"/>	<input type="checkbox"/>
LOCAL ANESTHETICS LIKE NOVOCAINE	<input type="checkbox"/>	<input type="checkbox"/>	FAINTING OR DIZZY SPELLS.....	<input type="checkbox"/>	<input type="checkbox"/>
PENICILLIN OR OTHER ANTIBIOTICS	<input type="checkbox"/>	<input type="checkbox"/>	DIABETES	<input type="checkbox"/>	<input type="checkbox"/>
SULFA DRUGS	<input type="checkbox"/>	<input type="checkbox"/>	AIDS OR HIV INFECTION.....	<input type="checkbox"/>	<input type="checkbox"/>
BARBITURATES, SEDATIVES OR SLEEPING PILLS	<input type="checkbox"/>	<input type="checkbox"/>	THYROID PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>
ASPIRIN.....	<input type="checkbox"/>	<input type="checkbox"/>	ALLERGIES.....	<input type="checkbox"/>	<input type="checkbox"/>
IODINE.....	<input type="checkbox"/>	<input type="checkbox"/>	ARTHRITIS OR RHEUMATISM.....	<input type="checkbox"/>	<input type="checkbox"/>
CODEINE.....	<input type="checkbox"/>	<input type="checkbox"/>	JOINT REPLACEMENT OR IMPLANT.....	<input type="checkbox"/>	<input type="checkbox"/>
ANY METALS (E.G., NICKEL, MERCURY, ETC.).....	<input type="checkbox"/>	<input type="checkbox"/>	EATING DISORDERS.....	<input type="checkbox"/>	<input type="checkbox"/>
LATEX/RUBBER	<input type="checkbox"/>	<input type="checkbox"/>	STOMACH ULCER.....	<input type="checkbox"/>	<input type="checkbox"/>
OTHER (PLEASE LIST) _____			KIDNEY TROUBLE.....	<input type="checkbox"/>	<input type="checkbox"/>
DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:			TUBERCULOSIS	<input type="checkbox"/>	<input type="checkbox"/>
RHEUMATIC HEART DISEASE OR FEVER	<input type="checkbox"/>	<input type="checkbox"/>	PERSISTENT COUGH.....	<input type="checkbox"/>	<input type="checkbox"/>
ARTIFICIAL HEART VALVE	<input type="checkbox"/>	<input type="checkbox"/>	COUGH THAT PRODUCES BLOOD.....	<input type="checkbox"/>	<input type="checkbox"/>
SCARLET FEVER.....	<input type="checkbox"/>	<input type="checkbox"/>	CANCER, TYPE _____	<input type="checkbox"/>	<input type="checkbox"/>
HEART DEFECT OR HEART MURMUR	<input type="checkbox"/>	<input type="checkbox"/>	RADIATION TREATMENTS.....	<input type="checkbox"/>	<input type="checkbox"/>
HEART TROUBLE, HEART ATTACK, OR ANGINA.....	<input type="checkbox"/>	<input type="checkbox"/>	CHEMOTHERAPY (CANCER, LEUKEMIA).....	<input type="checkbox"/>	<input type="checkbox"/>
CHEST PAIN.....	<input type="checkbox"/>	<input type="checkbox"/>	SEXUALLY TRANSMITTED DISEASE.....	<input type="checkbox"/>	<input type="checkbox"/>
SHORTNESS OF BREATH.....	<input type="checkbox"/>	<input type="checkbox"/>	EPILEPSY OR SEIZURES	<input type="checkbox"/>	<input type="checkbox"/>
PACEMAKER	<input type="checkbox"/>	<input type="checkbox"/>	ANEMIA	<input type="checkbox"/>	<input type="checkbox"/>
HEART SURGERY	<input type="checkbox"/>	<input type="checkbox"/>	GLAUCOMA	<input type="checkbox"/>	<input type="checkbox"/>
HIGH BLOOD PRESSURE.....	<input type="checkbox"/>	<input type="checkbox"/>	NERVOUSNESS/ANXIETY	<input type="checkbox"/>	<input type="checkbox"/>
CONGENITAL HEART PROBLEM.....	<input type="checkbox"/>	<input type="checkbox"/>	TONSILLITIS.....	<input type="checkbox"/>	<input type="checkbox"/>
SWELLING OF FEET, ANKLES, HANDS	<input type="checkbox"/>	<input type="checkbox"/>	TUMORS	<input type="checkbox"/>	<input type="checkbox"/>
HEPATITIS, JAUNDICE, OR LIVER DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	MENTAL HEALTH CARE	<input type="checkbox"/>	<input type="checkbox"/>
STROKE	<input type="checkbox"/>	<input type="checkbox"/>	BACK PROBLEMS.....	<input type="checkbox"/>	<input type="checkbox"/>
SINUS TROUBLE	<input type="checkbox"/>	<input type="checkbox"/>	CHEMICAL DEPENDENCY	<input type="checkbox"/>	<input type="checkbox"/>
LUNG OR BREATHING PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	MITRAL VALVE PROLAPSE.....	<input type="checkbox"/>	<input type="checkbox"/>
ASTHMA OR HAY FEVER.....	<input type="checkbox"/>	<input type="checkbox"/>	CORTISONE TREATMENT	<input type="checkbox"/>	<input type="checkbox"/>
			COLD SORES/FEVER BLISTERS.....	<input type="checkbox"/>	<input type="checkbox"/>
			HYPOGLYCEMIA	<input type="checkbox"/>	<input type="checkbox"/>

DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT I SHOULD KNOW ABOUT ☐ ☐

IF YES, PLEASE DESCRIBE _____

PATIENT INFORMATION (CONFIDENTIAL)

NAME _____ DATE _____
FIRST MI LAST
ADDRESS _____ CITY _____ STATE _____ ZIP _____
SOC. SEC. # _____ BIRTH DATE _____ HOME PHONE _____
CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED
IF COLLEGE STUDENT, FT. / PT., NAME OF SCHOOL _____ CITY _____ STATE _____
PATIENT'S OR PARENT'S EMPLOYER _____ WORK PHONE _____
BUSINESS ADDRESS _____ CITY _____ STATE _____ ZIP _____
SPOUSE OR PARENT'S NAME _____ EMPLOYER _____ WORK PHONE _____
WHOM MAY WE THANK FOR REFERRING YOU? _____
PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____
ADDRESS _____ HOME PHONE _____
BIRTHDAY _____ SOC. SEC. # _____
EMPLOYER _____ WORK PHONE _____
IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____
BIRTHDAY _____ SOCIAL SECURITY NUMBER _____ DATE EMPLOYED _____
NAME OF EMPLOYER _____ UNION OR LOCAL # _____ WORK PHONE _____
EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____
INSURANCE CO. _____ TEL # _____ GRP # _____ POLICY / ID # _____
INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____
BIRTHDAY _____ SOCIAL SECURITY NUMBER _____ DATE EMPLOYED _____
NAME OF EMPLOYER _____ UNION OR LOCAL # _____ WORK PHONE _____
EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____
INSURANCE CO. _____ TEL # _____ GRP # _____ POLICY / ID # _____
INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

X _____
SIGNATURE OF PATIENT OR PARENT IF MINOR

PATIENT NUMBER

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostics as deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. 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 a complete recital of any possible complications.
4. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

SIGNATURE

DATE

PARENT/RESPONSIBLE PARTY'S SIGNATURE

RELATIONSHIP TO PATIENT