

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 Broken/Chipped tooth
- Blisters/Sores in or around the mouth Teeth grinding Locking Jaw Sensitive tooth, teeth or gums
- Red, swollen or bleeding gums Ringing in Ears Bad breath Active Decay/Cavity(ies)

Other: _____

Do you require pre-medication? Yes No Don't know Have you ever been treated for Gum Disease? Y N

Previous Dentist: _____ (_____) _____
Name Address Phone#

Last Dental exam: ____ / ____ / ____ Last Dental X-rays: ____ / ____ / ____ Last Dental Cleaning: ____ / ____ / ____

Have you had problems with previous dental treatment? If so, explain: _____

Times a day you brush? ____ Times a week you floss? ____ Type of tooth brush bristles? Soft Medium Hard

Rate your Smile from 1-10: (EXCELLENT=10) ____ Would you like whiter teeth? Y N Have you had orthodontic treatment? Y N

Things you would change about your smile? _____

MEDICAL HISTORY & INFORMATION

What medications are you taking? Nerve pills Pain killers (including aspirin) Muscle relaxers Stimulants

Blood Thinners Tranquilizers Insulin Meds for Osteoporosis Vitamins/Supplements _____

Other(s), please list: _____

Have you ever taken: Bisphosphonates (ex. Aredia/Fosamax) Yes No Phen-fen/Redux Yes No

Do you have or have you had any of the following diseases, medical conditions or procedures?

- | | | | | |
|--|--|--|---|---|
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Heart Attack/Stroke | <input type="checkbox"/> Heart Surg./Pacemaker | <input type="checkbox"/> Heart Disease/Angina | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Cancer/Tumor(s)/Growth(s) | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Seizures/Epilepsy | <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Chemo/therapy/Radiation | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> X-ray or Cobalt Treatment | <input type="checkbox"/> Arthritis/Gout |
| <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Cosmetic Surgery | <input type="checkbox"/> G.I. Problems/Ulcers | <input type="checkbox"/> Frequent Thirst/Urination | <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Emphysema/Asthma | <input type="checkbox"/> Bleeding Problems/Anemia | <input type="checkbox"/> Chest Pains |
| <input type="checkbox"/> Tuberculosis TB | <input type="checkbox"/> Cold/Fever Blisters | <input type="checkbox"/> Diabetes/Hypoglycemia | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Bruise Easily |
| <input type="checkbox"/> HIV+/AIDS/ARC | <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Artificial Bones/Joints/Implants | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Alcohol/Drug Abuse | <input type="checkbox"/> Back/Neck Problems | <input type="checkbox"/> Severe/Frequent Headaches | <input type="checkbox"/> Nervousness |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Jaw Problems TMJ/TMD | <input type="checkbox"/> Sleep Apnea |

Please list any other surgeries or medical conditions you have or ever had: _____

Are you allergic to any of the following? Latex Penicillin / Amoxicillin Tetracycline Aspirin Codeine

Dental Anesthetics Foods: _____ Others: _____

Do you use tobacco? No Yes/How used? _____ How much? _____ How long? _____

Please rate your general health from 1-10: _____ Do you wear contact lenses? Yes No

For women: Are you taking Birth Control pills? Yes No Are you taking hormonal replacement? Yes No

Are you Pregnant? No Yes/How long? _____ Are you nursing? Y N How many children have you had? _____

■ 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.

■ I authorize the staff to perform any necessary services needed during diagnosis and 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.

I acknowledge that I have received a copy of the Summary of Privacy Notice.

Initials _____

Signature _____

Date ____ / ____ / ____

Adult Patient Parent or Guardian Spouse

UPDATE
(OFFICE USE)

Initials _____ / _____ / _____
Date

Comments _____

Initials _____ / _____ / _____
Date

Comments _____

Initials _____ / _____ / _____
Date

Comments _____