DENTAL HISTORY

	Yes	No
• DO YOU EVER FEEL PAIN IN ANY OF YOUR TEETH?	☐	☐
• ARE YOUR TEETH SENSITIVE TO HOT OR COLD?	☐	☐
• ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR FOODS OR LIQUIDS?	☐	☐
• DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?	☐	☐
• DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	☐	☐
• HAVE YOU EVER HAD ANY ORTHODONTIC WORK?	☐	☐
• HAVE YOU EVER HAD DIFFICULTY GETTING NUMB WITH LOCAL ANESTHETIC?	☐	☐

	Yes	No
• DO YOU EVER CLENCH OR GRIND YOUR TEETH?	☐	☐
• HAVE YOU EVER EXPERIENCED THE FOLLOWING PROBLEMS IN YOUR JAW?	☐	☐
◦ CLICKING?	☐	☐
◦ PAIN (JOINT, EAR, SIDE OF FACE)?	☐	☐
◦ DIFFICULTY IN OPENING OR CLOSING?	☐	☐
◦ DIFFICULTY IN CHEWING?	☐	☐
• HAVE YOU EVER HAD DIFFICULT EXTRACTIONS IN THE PAST?	☐	☐
• HAVE YOU EVER HAD PROLONGED BLEEDING FOLLOWING AN EXTRACTION?	☐	☐

• HOW OFTEN DO YOU FLOSS? _____

• HOW OFTEN DO YOU BRUSH? _____

MEDICAL HISTORY

PHYSICIAN'S NAME: _____ Phone Number: _____

PLEASE LIST ANY SERIOUS ILLNESSES OR OPERATIONS IN THE PAST 5 YEARS:

_____

HAVE YOU EVER BEEN PRE-MEDICATED BEFORE A DENTAL PROCEDURE? ☐ YES ☐ NO

PLEASE LIST ANY BLOOD TRANSFUSIONS WITH APPROXIMATE DATES: _____

(WOMEN) ARE YOU PREGNANT? ☐ YES ☐ NO NURSING? ☐ YES ☐ NO USING BIRTH CONTROL? ☐ YES ☐ NO

PLEASE MARK IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING:

☐ AIDS
☐ ANEMIA
☐ ARTHRITIS, RHEUMATISM
☐ ARTIFICIAL HEART VALVES
☐ ASTHMA
☐ BACK PROBLEMS
☐ BLOOD DISEASES
☐ CANCER
☐ CHEMICAL DEPENDENCY
☐ CHEMOTHERAPY
☐ CIRCULATORY PROBLEMS
☐ CORTISONE TREATMENTS
☐ COUGH, PERSISTENT
☐ COUGHING UP BLOOD
☐ DIABETES
☐ EPILEPSY
☐ FAINTING
☐ GLAUCOMA
☐ HEADACHES
☐ HEART MURMUR
☐ HEART PROBLEMS
☐ HEMOPHILIA
☐ HEPATITIS
☐ HIGH BLOOD PRESSURE
☐ HIV POSITIVE
☐ JAW PAIN
☐ KIDNEY DISEASE
☐ LIVER DISEASE
☐ MITRAL VALVE PROLAPSE
☐ NERVOUS PROBLEMS
☐ OSTEOPOROSIS
☐ PACEMAKER
☐ PSYCHIATRIC CARE
☐ RADIATION TREATMENT
☐ RESPIRATORY DISEASE
☐ RHEUMATIC FEVER
☐ SCARLET FEVER
☐ SHORTNESS OF BREATH
☐ SKIN RASH
☐ STROKE
☐ SWELLING OF FEET OR ANKLES
☐ THYROID PROBLEMS
☐ TOBACCO HABIT
☐ TONSILLITIS
☐ TUBERCULOSIS
☐ ULCER
☐ VENEREAL DISEASE

ARE YOU TAKING OR HAVE YOU EVER TAKEN BISPHOSPHONATES (such as Fosamax, Actonel, Boniva, Aredia, Zometa, or Reclast) FOR OSTEOPOROSIS, OR CHEMOTHERAPY FOR MULTIPLE MYELOMA OR OTHER CANCERS? ☐ YES ☐ NO

HAVE YOU EVER HAD AN ARTIFICIAL JOINT REPLACEMENT? IF SO, PROVIDE APPROXIMATE DATES AND DESCRIBE: _____

_____

PLEASE MARK IF YOU HAVE OR HAVE HAD AN ALLERGY OR BAD REACTION TO THE FOLLOWING:

☐ LOCAL ANESTHETICS
☐ PENICILLIN
☐ LATEX OR OTHER RUBBER PRODUCTS
☐ SULFA DRUGS
☐ ASPIRIN
☐ CODEINE

OTHER ALLERGIES:

_____
_____
_____

PLEASE LIST ALL OF THE MEDICATIONS YOU ARE TAKING:

_____
_____
_____
_____
_____
_____
_____
_____

Authorization

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize my dentist to take x-rays for diagnoses and treatment.

SIGNATURE: _____ **DATE:** _____