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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 pre-medication? ❑ Yes ❑ No ❑ Don't know

Previous Dentist: ____________ (Name) (____) ____________ (Phone#)

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

Times a day you brush? ____ Times a week you floss? ____

What type of tooth brush bristles do you use? ❑ Soft ❑ Medium ❑ Hard

How would you rate your smile? 1 2 3 4 5 6 7 8 9 10

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MEDICAL HISTORY

Are you taking any of the following medications? ❑ Nerve pills ❑ Pain killers (including aspirin)

❑ Muscle relaxers ❑ Stimulants ❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Other(s) ____________

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

Y N Heart Attack / Stroke	**Y N** Kidney Problems	**Y N** Cancer/Tumors	**Y N** Chemotherapy
Y N Heart Surg./Pacemaker	**Y N** Liver Problems	**Y N** Shingles	**Y N** Asthma
Y N Heart Murmur	**Y N** Respiratory Problems	**Y N** Hepatitis	**Y N** Difficulty Breathing
Y N Rheumatic Fever	**Y N** Sinus Problems	**Y N** HIV+/AIDS/ARC	**Y N** Diabetes/Hypoglycemia
Y N Mitral Valve Prolapse	**Y N** Stomach Problems/Ulcers	**Y N** Arthritis/ Rheumatism	**Y N** Leukemia
Y N Artificial Valves	**Y N** Psychiatric Problems	**Y N** Artificial Bones/Joints	**Y N** Anemia
Y N Heart Disease	**Y N** Venereal Disease	**Y N** Emphysema	**Y N** High/Low Blood Pressure
Y N Congenital Heart Defect	**Y N** Alcohol/Drug Abuse	**Y N** Fainting/Seizures/Epilepsy	**Y N** Bleeding Problems
Y N Chest Pains	**Y N** Tuberculosis TB	**Y N** Sever/Frequent Headaches	**Y N** Glaucoma
Y N Scarlet Fever	**Y N** Jaw Problems TMJ/TMD	**Y N** Frequent Neck Pain	**Y N** Back Problems

Please list any other medical condition(s) you have or ever had: ____________

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

❑ Dental Anesthetics ❑ 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 How many kids have **you** had? ____

Are you Pregnant? ❑ No ❑ Yes/How long? ____ Are you nursing? ❑ 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.
- 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.

Signature ____________ Date ____ / ____ / ____

❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

UPDATE (OFFICE USE)

Initials	Date	Comments
	/ /	
	/ /	
	/ /	

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET

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