5 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 (EXCELLENT=10) 1-10:____ Would you like whiter teeth? ❑Y ❑N Have you had orthodontic treatment? ❑Y ❑N

Things you would change about your smile?____________

6 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?

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

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

Signature ____________ ❑ Adult Patient ❑ Parent or Guardian ❑ Spouse Date / /

UPDATE
(OFFICE USE)

Initials ______ Date / /
Comments ______

Initials ______ Date / /
Comments ______

Initials ______ Date / /
Comments ______

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