DENTAL HISTORY

Reason for Today's Visit ____________________

Former Dentist ____________________ Address ____________________

Date of last dental care ____________________ Date of last dental X-rays ____________________

Check (√) if you have had problems with any of the following:

- [ ] Bad breath
- [ ] Bleeding gums
- [ ] Clicking or popping jaw
- [ ] Food collection between teeth
- [ ] Grinding teeth
- [ ] Loose teeth or broken fillings
- [ ] Periodontal treatment
- [ ] Sensitivity to cold
- [ ] Sensitivity to hot
- [ ] Sensitivity to sweets
- [ ] Sensitivity when biting
- [ ] Sores or growths in your mouth

How often do you floss? ____________________ How often do you brush? ____________________

MEDICAL HISTORY

Physician's Name ____________________ Date of Last Visit ____________________

Do you have any current health problems? Yes ☐ No. ☐ If yes, describe ____________________

(Women) Are you pregnant? Yes ☐ No. ☐ Nursing? Yes ☐ No. ☐ Taking birth control pills? Yes ☐ No ☐

Check (√) if you have or have had any of the following:

- [ ] AIDS
- [ ] Anemia
- [ ] Arthritis, Rheumatism
- [ ] Artificial Heart Valves
- [ ] Artificial Joints
- [ ] Asthma
- [ ] Bleeding Disorder
- [ ] Blood Disease
- [ ] Cancer
- [ ] Chemical Dependency
- [ ] Chemotherapy
- [ ] Circulatory Problems
- [ ] Cortisone Treatment
- [ ] Cosmetic surgery
- [ ] Diabetes
- [ ] Epilepsy/Seizures
- [ ] Glaucoma
- [ ] Headaches
- [ ] Heart Murmur
- [ ] Heart Problems
  Describe_______
- [ ] Hemophilia
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] HIV Positive
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Mitral Valve Prolapse
- [ ] Nervous Problems
- [ ] Pacemaker
- [ ] Psychiatric Care
- [ ] Radiation Treatment
- [ ] Respiratory Disease
- [ ] Rheumatic Fever
- [ ] Sinus Problem
- [ ] Stroke
- [ ] Thyroid Problems
- [ ] Tobacco Habit
- [ ] Tuberculosis
- [ ] Ulcer
- [ ] Venereal Disease

Is there any other medical or dental problem that the Dentist needs to know about you?

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MEDICATIONS (List all medications you are currently taking) ALLERGIES

____________________ ____________________

____________________ ____________________

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. The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance. I understand that where appropriate, credit reports may be obtained. I understand that I am financially responsible for all charges whether or not paid by insurance and that payments are due at time of service.

Patient Signature (Parent of child)________________________________Date___________________________________