DENTAL HISTORY

Reason for today's visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

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

☐ Bad Breath ☐ Grinding Teeth ☐ Sensitivity to Hot
☐ Bleeding Gums ☐ Loose Teeth or Broken Fillings ☐ Sensitivity to Sweets
☐ Clicking or Popping Jaw ☐ Periodontal Treatment ☐ Sensitivity when Biting
☐ Food Collection between the Teeth ☐ Sensitivity to Cold ☐ 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 _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you had any serious illnesses operations? ☐ Yes ☐ No If Yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If Yes, give approximate dates _____

(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:

☐ Anemia ☐ Congenital Heart Lesions ☐ Hepatitis ☐ Scarlet Fever
☐ Arthritis, Rheumatism ☐ Cortisone Treatments ☐ Hernia Repair ☐ Shortness of Breath
☐ Artificial Heart Valves ☐ Cough, Persistent ☐ High Blood Pressure ☐ Skin Rash
☐ Artificial Joints, Pins, etc... ☐ Cough up Blood ☐ HIV/AIDS ☐ Stroke
☐ Asthma ☐ Diabetes ☐ Jaw Pain ☐ Swelling of Feet or Ankles
☐ Back Problems ☐ Epilepsy ☐ Kidney Disease ☐ Thyroid Problems
☐ Bleeding Abnormally ☐ Fainting ☐ Liver Disease ☐ Tobacco Habit
☐ Blood Disease ☐ Glaucoma ☐ Mitral Valve Prolapse ☐ Tonsillitis
☐ Cancer ☐ Headaches ☐ Pacemaker ☐ Tuberculosis
☐ Chemical Dependency/Drug Addiction ☐ Heart Murmur ☐ Radiation Treatment ☐ Ulcer
☐ Chemotherapy ☐ Heart Problems ☐ Respiratory Disease ☐ Venereal Disease
☐ Circulatory Problems ☐ Hemophilia ☐ Rheumatic Fever

List medications you are currently taking and correlating diagnosis:

_____

_____

_____

Do you have any of the following drug allergies?
☐ Aspirin ☐ Codeine ☐ Nitrous Oxide
☐ Darvon ☐ Erythromycin ☐ Valium
☐ Percodan ☐ Penicillin ☐ Local Anesthetic
☐ Sulfa ☐ Tetracycline ☐ Latex
☐ Other _____

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financiall responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient