MEDICAL & DENTAL HISTORY

DENTAL HISTORY

Reason for Today's Visit: _____

Date of Last Dental Visit: _____ Date of Last X-Rays: _____

How do you feel about the condition of your teeth? _____

How do you feel about the color of your teeth? _____

Have you ever had TMJ (jaw) problems? _____

Are you nervous or anxious at the dentist? _____

MEDICAL HISTORY

Medical Physician's Name:_____ Address: _____

Have you been under the care of a physician/hospital in the last 2 years? _____ For?_____

Please list any major surgeries or illnesses you've had in the last 2 years: _____

_____

Women: Are you pregnant or nursing? ❑ Yes ❑ No Are you taking hormones or birth control? ❑ Yes ❑ No

Do you smoke or use tobacco? ❑ Yes ❑ No How long? _____

Have you ever had Botox or dermal fillers? ❑ Yes ❑ No Date of last treatment? _____

Are you now taking or have you taken any prescription medications during the last year? ❑ Yes ❑ No

If Yes, please list: _____

_____

Are you allergic or sensitive to any drugs or medications? ❑ Yes ❑ No If Yes, please list:

_____

_____

Please check (✓) Yes or No on the following:

Yes	No		Yes	No		Yes	No	
❑	❑	Abnormal Blood Pressure	❑	❑	Epilepsy or Seizures	❑	❑	Prolonged Bleeding
❑	❑	Allergies	❑	❑	Fainting	❑	❑	Prolonged Cough
❑	❑	Anemia	❑	❑	Glaucoma	❑	❑	Psychiatric Treatment
❑	❑	Angina	❑	❑	Headaches	❑	❑	Radiation Therapy
❑	❑	Arthritis	❑	❑	Heartburn or Acid Reflux	❑	❑	Rheumatic Fever
❑	❑	Artificial Heart Valves/Pacemaker	❑	❑	Heart Disease	❑	❑	Sickle Cell Anemia
❑	❑	Artificial Joints	❑	❑	Heart Murmur	❑	❑	Snoring or Sleep Apnea
❑	❑	Asthma	❑	❑	Hepatitis	❑	❑	Stroke
❑	❑	Blood Transfusions	❑	❑	Herpes	❑	❑	Thyroid Disease
❑	❑	Cancer	❑	❑	HIV	❑	❑	Tuberculosis
❑	❑	Chemical Dependency	❑	❑	Jaundice or Liver Disease	❑	❑	Ulcers or Sores
❑	❑	Chemotherapy	❑	❑	Kidney Disease	❑	❑	Venereal Disease
❑	❑	Congenital Heart Lesions	❑	❑	Organ Transplant	❑		Other: _____
❑	❑	Diabetes	❑	❑	Polio			_____

AUTHORIZATION & RELEASE

I have read the above questions and the answers I have given are true and to the best of my knowledge. I am indicating my consent for routine dental procedures such as X-rays, cleaning, fillings, crowns, and local anesthesia by signing below. I also understand that payment is due in full at time of treatment unless prior arrangements have been approved.

Patient or Parental Signature: _____ Date _____

Dentist's Signature: _____ Date _____

Patient Identification: Name: _____ DOB _____

Provider Review:

Date Initials

_____

_____

_____