

Date: _____

Patient Information

Patient's Name:

Chart Number: _____

Last _____ First _____ Middle Initial _____ Birthdate _____ Age _____ Sex: M F

It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

Dental History		Yes	No	Medical History		Yes	No
Is your present dental health good?				Do you have any current health problems?			
Do you wear dentures (partial or full)?				Are you under a physician's care now?			
If yes, are you happy with your dentures?				If yes, for what?			
Would you like to know about permanent replcmnt teeth?				What medications are you currently taking?			
Are you apprehensive about dental treatment?				Are you allergic to any medications?			
Have you ever had any periodontal (gum) treatments?				Have you ever taken Fen-Phen/Redux?			
Do your gums bleed, feel tender, or irritated?				Do you use cigars, cigarettes, pipe, or chewing tobacco?			
Are your teeth sensitive to hot, cold, sweets, pressure?				Do you have or have you ever had any of the following?			
Are you pleased with the appearance of your teeth?				AIDS/HIV Positive	Yes No	Hemophilia (abnrl bleeding)	Yes No
Are you aware that you are grinding or clenching your teeth?				Anaphylaxis	Yes No	Herpes	Yes No
Do you have headaches, earaches, or neck pains?				Anemia	Yes No	Hepatitis	Yes No
Have you worn braces on your teeth (orthodontics)?				Arthritis (rheumatism)	Yes No	High blood pressure	Yes No
Would you like your smile to look better or different?				Artificial heart valves	Yes No	Jaw pain	Yes No
Do you use dental floss regularly?				Artificial joints	Yes No	Kidney disease/malfunction	Yes No
Are you having dental problems now?				Asthma	Yes No	Liver disease	Yes No
If yes please tell us what:				Atopy (Allergy Prone)	Yes No	Mitral Valve Prolapse	Yes No
How long since you have seen a dentist?				Back problems	Yes No	Nervousness	Yes No
Date of last complete dental exam				Blood disease	Yes No	Pacemaker	Yes No
Last dental x-rays				Cancer	Yes No	Psychiatric care	Yes No
Name of Previous Dentist: _____				Chemical dependency	Yes No	Rapid weight gain/loss	Yes No
Address and Phone #: _____				Chemotherapy	Yes No	Radiation treatment	Yes No
				Circulatory problems	Yes No	Respiratory disease	Yes No
				Cortisone treatments	Yes No	Rheumatic/scarlet fever	Yes No
				Cough (persistent)	Yes No	Shortness of breath	Yes No
				Cough up blood	Yes No	Skin rash	Yes No
				Diabetes	Yes No	Stroke	Yes No
				Epilepsy	Yes No	Surgical implant	Yes No
				Fainting	Yes No	what type of implant:	
Are you:				Food allergies	Yes No	Swelling of feet/ankles	Yes No
Pregnant Yes No If yes, what month?				Glaucoma	Yes No	Thyroid disease	Yes No
Nursing Yes No				Headaches	Yes No	Tobacco habit	Yes No
Taking birth control medications Yes No				Heart attack	Yes No	Venereal disease	Yes No
				Heart murmur	Yes No	Ulcerative/Colitis	Yes No
				Heart Surgery	Yes No	Tuberculosis	Yes No
				Heart problems	Yes No		
				Please list what heart problems:			
				Material allergies (latex, metals, chemicals.)		Yes No	
				If yes list what allergies:			

Consent:

The undersigned hereby authorizes the doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's dental needs. I also authorize the 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 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 it is my responsibility to advise your office of any changes in the information contained on this form.

Patient/Guardian Signature _____ Dentist Signature _____