**5**

## Dental Information

**Reason for today's visit:**
☐ Urgent Care ☐ Maintenance Care ☐ Optimal Health Care

Are you in pain? ☐ Yes ☐ No How Long?___________________________

Please mark any of the following problems:
☐ Discomfort, clicking or popping in the jaw ☐ Lost/Broken Fillings ☐ Stained Teeth ☐ Red, swollen or bleeding gums
☐ Teeth Grinding ☐ Locking Jaw ☐ Ringing in Ears ☐ Bad Breath ☐ Sensitve tooth, teeth or gums
☐ Blisters/Sores in or around the mouth ☐ Broken/Chipped tooth
☐ Other _______________________________________________________________

Have you ever been told that you needed to be pre-medicated before each dental visit? ☐ Yes ☐ No
Do you feel nervous about having dental treatment?…………………………………… ☐ Yes ☐ No
Have you had a bad experience in a dental office?………………………………………☐ Yes ☐ No
Previous Dentist:_________________________________ Phone: ________________________
Last Dental Exam: __________________________ Last Dental X-rays:_______________________
Times a day you brush? ___________________Times a week you floss?_____________________
What type of tooth brush do you use? ☐ Soft ☐ Medium ☐ Hard

**6**

## Medical Information

**Are you allergic or have you reacted adversely to any of the following medications:**
☐ Aspirin ☐ Iodine ☐ Valium ☐ Sulfa Drugs ☐ Erythromycin ☐ Latex ☐ Demerol
☐ Sleeping Pills ☐ Penicillin ☐ Codeine ☐ Percodan ☐ Tetracycline ☐ Codeine
☐ Nickel/Costume Jewelry ☐ Cephalosporin (Keflex/Ceclor) ☐ Nitrous Oxide ☐ Local Anesthetic
☐ Other ______________________________________________________________________________

**Please mark any of the following, which you have had or have at present:**
☐ Mitral Valve Prolapse ☐ Cosmetic Surgery ☐ Glaucoma ☐ HIV Virus ☐ Heart Failure ☐ Emphysema
☐ Heart Disease or Attack ☐ A.I.D.S. ☐ Cough ☐ Asthma ☐ Tuberculosis (TB) ☐ Hepatistis A
☐ Fainting or Dizzy Spells ☐ Hepatitis B ☐ Hepatitis C ☐ Angina Pectoris ☐ Hay Fever ☐ Heart Murmur
☐ Yellow Jaundice ☐ Heart Surgery ☐ Sinus Trouble ☐ Liver Disease ☐ Allergies or Hives ☐ Diabetes
☐ High Blood Pressure ☐ Anemia ☐ Thyroid Disease ☐ Drug Addiction ☐ Hemophilia ☐ Sickle Cell Disease
☐ X-Ray or Cobalt Treatment ☐ Ulcers ☐ Rheumatism ☐ Kidney Trouble ☐ Heart Pacemaker ☐ Psychiatric Treatment
☐ Chemotherapy (Cancer) ☐ Arthritis ☐ Fever Blisters ☐ Rheumatic Fever ☐ Blood Transfusion ☐ Artificial Heart Valve
☐ Congenital Heart Lesions ☐ Stroke ☐ Scarlet Fever ☐ Bruise Easily ☐ Pain in Jaw Joints ☐ Epilepsy or Seizures
☐ Cortisone Medicine ☐ Artificial Joints (Hip, Knee) ☐ Venereal Disease (Syphilis, Gonorrhea)
☐ Other ______________________________________________________________________________

Have you been a patient in the hospital during the past two years?…………………………………… ☐ Yes ☐ No
Have you been under the care of a medical doctor during the past two years?………………………...☐ Yes ☐ No
Physician's Name__________________ Physician's Address__________________ Physician's Phone _________________
Have you taken any medicine or drugs during the past two years?……………………………………..☐ Yes ☐ No
Are you now taking any medication, drugs or pills?…………………………………………………...☐ Yes ☐ No
If YES, please list:_____________________________________________________________
Have you been tested for the HIV (AIDS) Virus?………………………………………………………...☐ Yes ☐ No
If YES, was is positive ☐ negative ☐ Date last tested___________________________
Do your ankles swell during the day?…………………………………………………………………… ☐ Yes ☐ No
Do you use more than two pillows to sleep?…………………………………………………………... ☐ Yes ☐ No
Have you lost or gained more than 10 pounds in the past year?………………………………………. ☐ Yes ☐ No
Do you ever wake up from sleep short of breath?……………………………………………………... ☐ Yes ☐ No
Are you on a special diet?……………………………………………………………………………... ☐ Yes ☐ No
Has your medical doctor ever said you have a cancer or tumor?………………………………………. ☐ Yes ☐ No
Do you have any disease, condition, or problem not listed?…………………………………………... ☐ Yes ☐ No
Do you use any tobacco products?…………………………………………………………………….. ☐ Yes ☐ No
If so, how much per day and what kind?___________________________________________________
Do you use any alcohol products?……………………………………………………………………... ☐ Yes ☐ No
If so, how much per day/week/month?_______________________________________________________

**FOR WOMEN ONLY:**
Are you pregnant?…..☐ YES ☐ NO If YES, what month?____________ Are you taking birth control pills?….☐ Yes ☐ No

**THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE**

**Patient Signature:**_______________________________________________ **Dated:**_________________________________

**CONSENT:**
The undersigned hereby authorizes 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 in connection with the patient and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for my dependents or myself is mine, due and payable at the time services are rendered unless fianacial arrangements have been made.

**Patient Signature:**_______________________________________________ **Dated:**_________________________________