Name ______________________________ Date of Birth ______________

Dental disease is caused by a combination of complex causative factors and the following questions are designed to help us identify them. The success of therapy is dependent upon this. Therefore, although some of the following questions may seem unrelated to your dental condition, they are all associated with proper management of your oral health and are confidential.

Has there been any change in your general health within the past year? O Yes O No
When was your last physical examination? ______________________________

Are you now under the care of a physician? O Yes O No
If so, what is the condition being treated? ______________________________
Please give the name, address and phone number of your physician ______________________________
____

Have you been hospitalized or had a serious illness within the past five (5) years? O Yes O No
If so, what was the problem? ______________________________
Have you ever had a head or neck injury? O Yes O No
Are you on a special diet? O Yes O No
Do you use tobacco products? O Yes O No If yes, how much? ______________

Medications: Are you taking any of the following?

Medication		Medication	
Antibiotics	O Yes O No	Tranquilizers	O Yes O No
Blood thinners	O Yes O No	Aspirin	O Yes O No
Blood pressure	O Yes O No	Insulin	O Yes O No
Steroids	O Yes O No	Nitroglycerin	O Yes O No

Please list all medications you are taking ______________ ______________
______________ ______________ ______________
______________ ______________ ______________

Are you allergic to any of the following? Circle all that apply.

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Sulfa Drugs

Other: If yes, please explain ______________________________

Do you have or have you had any of the following?

Condition		Condition		Condition		Condition	
Aids/HIV Positive	O Yes O No	Congenital Heart Disorder	O Yes O No	Heart Trouble/Disease	O Yes O No	Radiation Treatments	O Yes O No
Alzheimer's	O Yes O No	Convulsions	O Yes O No	Hemophilia	O Yes O No	Recent Weight Loss	O Yes O No
Anaphylaxis	O Yes O No	Cortisone Medicine	O Yes O No	Hepatitis A	O Yes O No	Renal Dialysis	O Yes O No
Anemia	O Yes O No	Diabetes	O Yes O No	Hepatitis B or C	O Yes O No	Rheumatic Fever	O Yes O No
Angioplasty/Bypass	O Yes O No	Drug Addition	O Yes O No	Herpes	O Yes O No	Rheumatism	O Yes O No
Anxiety/Depression	O Yes O No	Easily Winded	O Yes O No	High Blood Pressure	O Yes O No	Scarlet Fever	O Yes O No
Angina	O Yes O No	Emphysema	O Yes O No	Hives or Rash	O Yes O No	Shingles	O Yes O No
Arthritis/Gout	O Yes O No	Epilepsy or Seizures	O Yes O No	Hypoglycemia	O Yes O No	Sickle Cell Disease	O Yes O No
Artificial Heart Valve	O Yes O No	Excessive Bleeding	O Yes O No	Irregular Heartbeat	O Yes O No	Sinus Trouble	O Yes O No
Artificial Joint	O Yes O No	Excessive Thirst	O Yes O No	Kidney Problems	O Yes O No	Spina Bifida	O Yes O No
Asthma	O Yes O No	Fainting Spells/Dizziness	O Yes O No	Leukemia	O Yes O No	Stomach/Intestinal Disease	O Yes O No
Atherosclerosis/High Cholesterol	O Yes O No	Frequent Cough	O Yes O No	Low Blood Pressure	O Yes O No	Stroke	O Yes O No
Blood Disease	O Yes O No	Frequent Diarrhea	O Yes O No	Lung Disease	O Yes O No	Swelling of Limbs	O Yes O No
Blood Transfusion	O Yes O No	Frequent Headaches	O Yes O No	Liver Disease	O Yes O No	Thyroid Disease	O Yes O No
Breathing Problem	O Yes O No	Genital Herpes	O Yes O No	Lupus/Autoimmune Disease	O Yes O No	Tonsillitis	O Yes O No
Bruise Easy	O Yes O No	Glaucoma	O Yes O No	Mitral Valve Prolapse	O Yes O No	Tuberculosis	O Yes O No
Cancer	O Yes O No	Hay Fever	O Yes O No	Pain in Jaw Joints	O Yes O No	Tumors or Growths	O Yes O No
Chemotherapy	O Yes O No	Heart Attack/Failure	O Yes O No	Parathyroid Disease	O Yes O No	Ulcers	O Yes O No
Chest Pains	O Yes O No	Heart Murmur	O Yes O No	Parathyroid Disease	O Yes O No	Venereal Disease	O Yes O No
Cold Sores/Fever Blisters	O Yes O No	Heart Pace Maker	O Yes O No	Psychiatric Care	O Yes O No	Yellow Jaundice	O Yes O No

Have you ever had any serious illness not listed above? O Yes O No If yes, please explain? ______________
Comments: ______________________________
____

Women: Are you
Pregnant/Trying to get Pregnant? O Yes O No Taking oral contraceptives? O Yes O No Nursing? O Yes O No

(OVER)

DENTAL HISTORY

Have you ever had any serious trouble associated with any previous dental treatment? O Yes O No
If yes, please explain: ______________________________

Do you presently have any dental discomfort or problem? O Yes O No
If yes, please explain: ______________________________

Do you have:

Receding gums?	O Yes	O No	Bad breath?	O Yes	O No	Dry mouth?	O Yes	O No
Painful gums?	O Yes	O No	Bad taste?	O Yes	O No	Sensitive teeth?	O Yes	O No
Bleeding gums?	O Yes	O No						

Have you had surgery or x-ray treatment for a tumor, growth, or other condition of your mouth or lips? O Yes O No

Do you grind or clench your teeth?	O Yes	O No
Do you wake up with headaches/sore teeth?	O Yes	O No
Does your jaw ever pop or lock when opening or closing?	O Yes	O No
Have immediate relatives lost all their teeth?	O Yes	O No
Would you be disturbed if you had to lose your teeth and wear false teeth?	O Yes	O No
Have you ever had a "deep cleaning", root planning, or gum surgery?	O Yes	O No
Are you happy with your smile?	O Yes	O No
Do you like the color of your teeth?	O Yes	O No

What medicine works best for you to relieve pain? ______________________________
What brand/type of toothpaste do you use? ______________________________
Have you ever taken antibiotics before a dental appointment? O Yes O No If yes, which one? ____________
Describe your past dental care ______________________________
____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN ______________________ DATE ____________

People go to dentists for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem, as well as the symptoms, corrected and relieved (Corrective Care). Still others want whatever is malfunctioning in their mouth brought to the highest state of health possible with dental care (Comprehensive Care). We will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ Relief Care ☐ Corrective Care ☐ Comprehensive Care ☐ Check have if you want the Doctor to select the type of care appropriate for your condition.

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 (Name of Patient)____________________ and further authorize any 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 the responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1 1/2% finance charge (18% annually) will be added to any balance over 60 days. In the event of default I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as my be required to effect collection of this note.

Patient ______________________ Date __________ Witness ______________________

Parent or Responsible Party ______________________ Relationship to Patient ______________