Dental History

What would you like us to do today? ______ Are you in dental discomfort today? ______

Former Dentist ______ Address ______

Dentist's Email ______ Phone ______

Date of last dental care ______ Date of last x-rays ______

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

- ❑ Y Bad breath
- ❑ Y Bleeding gums
- ❑ Y Clicking or popping jaw
- ❑ Y Food collection between teeth
- ❑ Y Grinding or clenching teeth
- ❑ Y Loose teeth or broken fillings
- ❑ Y Periodontal treatment
- ❑ Y Sensitivity to cold
- ❑ Y Sensitivity to hot
- ❑ Y Sensitivity to sweets
- ❑ Y Sensitivity when biting
- ❑ Y Sores or growths in mouth

How often do you brush? ______ Floss? ______

How do you feel about the appearance of your teeth? ______

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❑ Y ❑ N

Other information about your dental health or previous treatment ______

MEDICAL HISTORY

Physician's name ______ Phone ______

Date of last visit ______ Have you had any serious illnesses or operations? ❑ Y ❑ N

If yes, describe ______

Are you currently under physician care? ❑ Y ❑ N If yes, describe ______

Have you ever had a blood transfusion? ❑ Y ❑ N If yes, give approximate dates ______

Have you ever taken Fen-Phen/Redux? ❑ Y ❑ N

Women: Are you pregnant? ❑ Y ❑ N Nursing? ❑ Y ❑ N Taking birth control pills? ❑ Y ❑ N

Check (✓) **YES IF YOU HAVE HAD ANY OF THE FOLLOWING:**

- ❑ Y AIDS/HIV Positive
- ❑ Y Anaphylaxis
- ❑ Y Anemia
- ❑ Y Arthritis, Rheumatism
- ❑ Y Artificial heart valves
- ❑ Y Artificial joints
- ❑ Y Asthma
- ❑ Y Atopic (allergy prone)
- ❑ Y Back problems
- ❑ Y Blood disease
- ❑ Y Cancer
- ❑ Y Chemical dependency
- ❑ Y Chemotherapy
- ❑ Y Circulatory problems
- ❑ Y Cortisone treatments
- ❑ Y Cough, persistent
- ❑ Y Cough up blood
- ❑ Y Diabetes
- ❑ Y Epilepsy
- ❑ Y Fainting
- ❑ Y Food allergies
- ❑ Y Glaucoma
- ❑ Y Headaches
- ❑ Y Heart murmur
- ❑ Y Heart problems

Describe ______

- ❑ Y Hemophilia/ Abnormal bleeding
- ❑ Y Herpes
- ❑ Y Hepatitis
- ❑ Y High blood pressure
- ❑ Y Jaw pain
- ❑ Y Kidney disease or malfunction
- ❑ Y Liver disease
- ❑ Y Material allergies (**latex**, wool, metal, chemicals)
- ❑ Y Mitral valve prolapse
- ❑ Y Nervous problems
- ❑ Y Pacemaker/ Heart surgery
- ❑ Y Psychiatric care
- ❑ Y Rapid weight gain or loss
- ❑ Y Radiation treatment
- ❑ Y Respiratory disease
- ❑ Y Rheumatic/Scarlet fever
- ❑ Y Shingles
- ❑ Y Shortness of breath
- ❑ Y Skin rash
- ❑ Y Spina Bifida
- ❑ Y Stroke
- ❑ Y Surgical implant
- ❑ Y Swelling of feet or ankles
- ❑ Y Thyroid disease or malfunction
- ❑ Y Tobacco habit
- ❑ Y Tonsillitis
- ❑ Y Tuberculosis
- ❑ Y Ulcer/Colitis
- ❑ Y Venereal disease

Is patient currently taking any medications? If yes, list all:

______

______

Does patient have drug allergies? If yes, list all:

______

______

AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status,I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature ______ Date ______

Payment is due in full at time of treatment, unless prior arrangements have been approved.

© SmartPractice™