

DENTAL HISTORY

How can we make your visit more comfortable?	
Do you have a specific dental problem?	Where?
Are you in pain? <input type="checkbox"/> Cold <input type="checkbox"/> Hot <input type="checkbox"/> Sweet <input type="checkbox"/> Throbbing <input type="checkbox"/> Ache	Where?
Do your gums ever bleed?	Where?
Do you like your smile?	Why not?
Does food catch between your teeth?	Where?
Do you ever have clicking, popping or discomfort in your jaws?	Discuss
Do you grind your teeth at night or during the day?	Discuss
Name of previous dentist:	
Date of last full mouth x-rays (21 small films or panoramic) if known:	
Last dental visit date and reason	Reason:

MEDICAL HISTORY

Have you ever had any complications following dental treatment? Yes No
 If yes, please explain _____

Do you require antibiotic pre medication before dental treatment? No Yes Drug? _____

Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
 If yes please explain _____

Name of Physician: _____ Phone: _____

Are you taking any medications, pill or drug? Which? _____

Are you allergic to any medications, pill or drug? Which? _____

Are you allergic to any medications or substances? _____

Aspirin Penicillin Codeine Acrylic Metal Sulfa Latex Rubber Other _____

WOMEN Not Pregnant Pregnant Nursing Taking oral contraceptives Which? _____

SYSTEMS REVIEW

Please circle any relevant condition:

HEART

Rheumatic Fever
 Heart murmur
 Swelling of the ankles
 Stroke
 Valve Prosthesis
 Chest pain
 Angina
 Shortness of breath
 Blood pressure - High/Low
 Pacemaker
 Heart Attack

JOINTS

Prosthesis
 Arthritis

LUNGS
 Asthma
 Sinuses
 Bronchitis
 Emphysema
 Hayfever
 Persistent Cough
 Active TB

LIVER

Hepatitis A B C
 Cirrhosis
 Jaundice
 Failure

KIDNEYS

Stones
 Dialysis
 Transplant

BLOOD

Anemia

Hemophilia
 Bruise Easily
 Bleed Excessively
 HIV positive
 AIDS

OTHER

Cancer
 Radiation Therapy
 Chemotherapy
 Diabetes
 Glaucoma
 Epilepsy
 Thyroid disease

OFFICE POLICY

Payments: Expect at the time of service

Appointments: 48 hours of notice is appreciated to avoid cancellation charge

Insurance: Patient Balance is due upon receipt of office billing statement

Truth in Lending: Account balances over 30 days will be subject to an interest charge of 18% per annum.

Patient or Guardian Signature _____ **Date:** _____