## Dental History

What is your primary dental concern today?

_____

Are you in discomfort today? ○Y ○N Former Dentist_____ Date of last visit _____

Why did you choose this office? _____

Who may we thank for your referral? _____

Have you had problems with any of the following:

| | | | |
|---|---|---|---|
| ○ bad breath | ○ food collection between teeth | ○ sensitivity to cold | ○ sensitivity to biting |
| ○ bleeding gums | ○ grinding/clenching teeth | ○ sensitivity to hot | ○ sores/growths in mouth |
| ○ clicking/popping jaw | ○ loose teeth/broken fillings | ○ sensitivity to sweets | ○ periodontal treatment |

How often do you brush?_____ How often do you floss? _____

How do you feel about your teeth?

_____

Other information regarding your dental health

_____

## Medical History

Physician's name _____ Phone # _____

Date of last visit _____ Have you had any serious illnesses/operations? ○Y ○N

If yes, describe _____

Are you currently under a physician's care? ○Y ○N If yes, describe

_____

Have you ever had a blood transfusion? ○Y ○N If yes, give dates

_____

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

Have you had any of the following:

| | | | |
|---|---|---|---|
| ○ AIDS/HIV | ○ circulatory problems | ○ high/low blood pressure | ○ shortness of breath |
| ○ anaphylaxis | ○ cortisone treatments | ○ kidney disease/malfunction | ○ skin rash |
| ○ anemia | ○ cough, persistent | ○ liver disease | ○ spina bifida |
| ○ arthritis/rheumatism | ○ diabetes | ○ mitral valve prolapsed | ○ stroke |
| ○ artificial heart valves | ○ epilepsy | ○ nervous problems | ○ surgical implants |
| ○ artificial joints | ○ glaucoma | ○ pacemaker/heart surgery | ○ swelling of feet/ankles |
| ○ asthma | ○ headaches/migraines | ○ psychiatric care | ○ thyroid disease/malfunction |
| ○ back problems | ○ heart murmur | ○ rapid weight gain/loss | ○ tobacco habit |
| ○ blood disease | ○ heart problems | ○ radiation treatment | ○ tonsillitis |
| ○ cancer | ○ hemophilia/excessive bleeding | ○ respiratory disease | ○ tuberculosis |
| ○ chemical dependency | ○ herpes | ○ rheumatic/scarlet fever | ○ ulcer/colitis |
| ○ chemotherapy | ○ hepatitis | ○ shingles | ○ venereal disease |

Medications: _____
Allergies:_____

## Authorization/Consent for Treatment

I have reviewed the information on this page 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 Dr. Smith and/or such associates or assistants as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments. I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, and temporary or rarely, permanent numbness, and muscle soreness. I understand that occasionally needles break and may require surgical retrieval. I understand that as part of dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.
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. Outstanding patient balances will incur charges to cover all collection costs. I understand that I am financially responsible for all charges regardless of insurance payment.

Signature _____ Date _____