Dental Health History

Reason for today's visit_____

Previous Dentist_____ Address_____

Date of last dental care_____Last Dental x-rays_____

Please mark (X) if you have had trouble or concerns with any of the following:

____Bad Breath ____Worn Teeth ____Clicking or popping jaw

____Chipped teeth\broken fillings ____Food collection between teeth ____Other_____

____Gum Disease ____Sensitivity to Cold / Hot / Sweets / Biting

Do you like your smile?_____

Medical History

Physician's Name_____ Date of last visit_____

Previous hospitalizations, illnesses, or operations (please describe and give approximate dates)_____
_____

Women: Are you pregnant? ___Yes / ___No Are you nursing? ___Yes / ___No

Please mark (X) if you have or have had any of the following:

___AIDS	___Cortisone Treatments	___Hepatitis	___Rheumatic Fever
___Anemia	___Cough, Persistent	___High Blood Pressure	___Scarlet Fever
___Arthritis, Rheumatism	___Cough up Blood	___HIV Positive	___Shortness of Breath
___Artificial Heart Valves	___Diabetes	___Jaw Pain	___Skin Rash
___Artificial Joints	___Epilepsy	___Kidney Disease	___Stroke
___Asthma	___Fainting	___Liver Disease	___Swelling feet/ankles
___Back Problems	___Glaucoma	___Mitral Valve Prolapse	___Thyroid Problems
___Blood Disease	___Headaches	___Nervous Problems	___Tobacco Habit
___Cancer	___Heart Murmur	___Pace Maker	___Tonsillitis
___Chemical Dependency	___Heart Problems	___Psychiatric Care	___Tuberculosis
___Chemotherapy	Describe_____	___Radiation Treatment	___Ulcer
___Circulatory Problems	___Hemophilia	___Respiratory Disease	___Venereal Disease

Please list any medications you are currently taking_____

Please list any allergies_____

Authorization

I have reviewed this questionnaire and answered its questions accurately, to the best of my knowledge. I understand that the answers I have provided will be used by the dentist to determine appropriate dental treatment, and I agree to notify the dentist if any change in my health status should occur.

I authorize the dentist to release all information necessary to secure payment of benefits. I authorize my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize use of this signature on all insurance submissions.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf.

Signature_____ Date_____