DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____ Date of Last Visit _____

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

Please check any of the following conditions that apply to you:

( ) Bad Breath	( ) Grinding teeth	( ) Sensitivity to cold/hot
( ) Bleeding Gums	( ) Loose teeth	( ) Sensitivity to sweets
( ) Clicking or popping of jaw	( ) Periodontal treatment	( ) Sensitivity when biting
( ) Food collecting between teeth	( ) Broken fillings	( ) Sores or growths in mouth

MEDICAL HISTORY

Physician _____ Phone # _____ Last Visit _____

Please list all medications you are currently taking _____

_____

_____

_____

Are you allergic to any of the following:

Aspirin	NO ( )	YES ( )	Acrylic	NO ( )	YES ( )	Penicillin	NO ( )	YES ( )
Latex	NO ( )	YES ( )	Codeine	NO ( )	YES ( )	OTHER:		

WOMEN:

Are you Pregnant? NO ( ) YES ( ) Nursing? NO ( ) YES ( ) On birth control pills? NO ( ) YES ( )

Do you have a history of the following?

( ) Anemia	( ) Cough(Persistent)	( ) Hepatitis	( ) Rheumatic Fever
( ) Arthritis, Rheumatism	( ) Diabetes	( ) High Blood Pressure	( ) Scarlet Fever
( ) Artificial Heart Valves	( ) Epilepsy	( ) HIV/AIDS	( ) Shortness of Breath
( ) Artificial Joints	( ) Fainting	( ) Jaw Pain	( ) Skin Rash
( ) Asthma	( ) Glaucoma	( ) Kidney Disease	( ) Stroke
( ) Back Problems	( ) Headaches	( ) Liver Disease	( ) Swelling Feet/Ankles
( ) Blood Disease	( ) Heart Problems	( ) Mitral Valve Prolapse	( ) Thyroid Problems
( ) Cancer	Describe_____	( ) Pacemaker	( ) Tobacco Habit
( ) Chemical Dependency	_____	( ) Psychiatric Care	( ) Tuberculosis
( ) Chemotherapy	_____	( ) Radiation Treatment	( ) Ulcer
( ) Circulatory Problems	( ) Hemophilia	( ) Respiratory Disease	( ) Venereal Disease

OTHER: _____

AUTHORIZATION: I understand that I am responsible for all cost of dental treatment and authorize payment of dental benefits directly to this office. I hereby authorize this dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information contained on this form is correct to the best of my knowledge. I will not hold this office or any member of its staff responsible for any errors or omissions that I may have made in the completion of this form.

FINANCE CHARGE: If I do not pay the entire new balance of my account within 60 days of the billing date, a Finance Charge of 1.5% will be added to the account for each subsequent monthly billing period. In the case of default of payment, I promise to pay any interest accrued on the balance due, along with any collection costs and reasonable attorney fees incurred in the settlement of the account.

Signature _____ Date: _____
(Patient/Parent/Guardian)

I can best be reached: Home # _____ Work # _____ Mobile/Beeper # _____