



Reason for today's visit :  Exam  Emergency  Consultation

Are you in pain?  No  Yes How Long? \_\_\_\_\_

Please indicate  if you have any of the following problems:

Discomfort, clicking or popping in jaw.  Lost/Broken filling(s)  Stained teeth

Red, swollen or bleeding gums.  Teeth grinding  Locking jaw

Sensitive tooth, teeth or gums.  Ringing in Ears  Bad breath

Blisters/Sores in or around the mouth.  Broken/Chipped tooth

Other: \_\_\_\_\_

**Do you require antibiotics before dental treatment?**  Yes  No  Don't know

Previous Dentist: \_\_\_\_\_ (\_\_\_\_)

Last Dental Exam: \_\_\_\_/\_\_\_\_/\_\_\_\_ Last Dental X-rays: \_\_\_\_/\_\_\_\_/\_\_\_\_

Times a day you brush? \_\_\_\_\_ Times a week you floss? \_\_\_\_\_

What type of tooth brush bristles do you use?  Soft  Medium  Hard

Do you use an electric toothbrush? \_\_\_\_\_ If so, what kind? \_\_\_\_\_

How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

**UPDATES**

Initials \_\_\_\_\_ Date \_\_\_\_\_

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Health/Medication Changes \_\_\_\_\_

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Initials \_\_\_\_\_ Date \_\_\_\_\_

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Health/Medication Changes \_\_\_\_\_

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Initials \_\_\_\_\_ Date \_\_\_\_\_

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Health/Medication Changes \_\_\_\_\_

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Initials \_\_\_\_\_ Date \_\_\_\_\_

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Health/Medication Changes \_\_\_\_\_

Are you taking any of the following medications? Anti-anxiety or Anti-depressant \_\_\_\_\_ Insulin \_\_\_\_\_

Pain killers (including aspirin) \_\_\_\_\_ Muscle relaxers \_\_\_\_\_ Blood Thinners \_\_\_\_\_

Tranquilizers \_\_\_\_\_ High Blood Pressure \_\_\_\_\_ Other(s), please list: \_\_\_\_\_

**Do you have or have you had any of the following diseases, medical conditions or procedures?**

Y N Heart Attack/Stroke	Y N Diabetes/Hypoglycemia	Y N Kidney Problems	Y N Hepatitis
Y N Heart Surgery/Pacemaker	Y N Chest Pains	Y N Liver Problems	Y N HIV+/AIDS/ARC
Y N Heart Murmur	Y N Asthma (active:bring inhaler)	Y N Stomach Problems/Ulcers	Y N Chemotherapy
Y N Rheumatic or Scarlet Fever	Y N Respiratory Problems	Y N Severe/Frequent Headaches	Y N Shingles
Y N Mitral Valve Prolapse	Y N Sinus Problems	Y N Frequent Neck Pain	Y N Nervousness
Y N Artificial Valves	Y N Difficulty Breathing	Y N Jaw Problems TMJ/TMD	Y N Glaucoma
Y N Heart Disease	Y N Emphysema	Y N Back Problems	Y N Psychiatric Problems
Y N Congenital Heart Defect	Y N Fainting/Seizures/Epilepsy	Y N Thyroid Problems	Y N Alcohol/Drug Abuse
Y N High/Low Blood Pressure	Y N Tuberculosis TB	Y N Arthritis/Rheumatism	Y N Cancer/Tumors
Y N Bleeding Problems	Y N Anemia	Y N Venereal Disease	Y N X-ray or Cobalt Treatment
Y N Artificial Bones/Joints	Y N Leukemia		

Please list any other surgeries or medical conditions you have or ever had: \_\_\_\_\_

Are you allergic to any of the following medications?  Penicillin/Amoxicillin  Erythromycin  Aspirin  Codeine

Tetracycline  Dental Anesthetics  Others: \_\_\_\_\_

Do you use tobacco?  No  Yes/How used? \_\_\_\_\_ How much? \_\_\_\_\_ How Long? \_\_\_\_\_

Rate your general health from 1-10 (10 being best): \_\_\_\_\_

**For Women:** Are you taking Birth Control pills?  Yes  No

Are you pregnant?  No  Yes/How far along? \_\_\_\_\_ Are you nursing?  Yes  No

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
  - Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection fees, interest charges and any other expenses incurred in collecting your account.
  - I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims or prepare referrals to another provider of services..
  - I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.
  - **In consideration of our employees and other patients, we ask that you refrain from wearing any type of fragrances to your appointments.**
- Signature: \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_
- Adult Patient  Parent or Guardian  Spouse