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DENTAL INFORMATION

Reason for today's visit: Exam Emergency Consultation

Are you in pain? No Yes How Long? _____

Please indicate 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 pre-medication? Yes No Don't know

Previous Dentist: _____ (_____) _____
Name Phone#

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

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

MEDICAL HISTORY

Are you taking any of the following medications? Nerve pills Pain killers (including aspirin)

Muscle relaxers Stimulants Blood Thinners Tranquilizers Insulin

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

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

Are you allergic to any of the following? Latex Penicillin / Amoxicillin Tetracycline Aspirin

Dental Anesthetics Others: _____

Do you use tobacco? No Yes/How used? _____ How much? _____ How long? _____

Please rate your general health from 1-10: _____ Do you wear contact lenses? Yes No

Have you ever taken the drug Phen-fen and or Redux? Yes No

For women: Are you taking Birth Control pills? Yes No How many children have you had? _____

Are you Pregnant? No Yes/How long? _____ 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 agency 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.
- 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.

Signature _____ Date ____ / ____ / ____

Adult Patient Parent or Guardian Spouse

UPDATE (OFFICE USE)

Initials _____ / _____ / _____
Date

Comments _____

Initials _____ / _____ / _____
Date

Comments _____

Initials _____ / _____ / _____
Date

Comments _____



PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET.