DENTAL HISTORY	Y	N
Is your present dental health POOR?		
Do you wear DENTURES?		
Are you unhappy with your DENTURES?		
Would you like to know about Permanent Replacements?		
Are you APPREHENSIVE about dental treatment?		
Have you had any PERIODONTAL (GUM) treatments?		
Do your gums BLEED, or feel TENDER or IRRITATED?		
Are your teeth SENSITIVE to hot, cold, sweets, pressure, etc?		
Are you aware of GRINDING or CLENCHING your teeth?		
Do you have HEADACHES, EARACHES, or NECK PAINS?		
Have you worn BRACES on your teeth (ORTHODONTICS)		
Do you have DISCOLORED teeth that bother you?		
Would you like your smile to LOOK BETTER or DIFFERENT?		
Do you REGULARLY use DENTAL FLOSS?		

Name of Previous Dentist::_______________________

City: _______________________ **State:** _____________

Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment	
FEAR of Pain #	**LACK of Concern#**
COST of Treatment#	**MISSING work time #**

How long since you have seen a dentist? _________________________ ____
Are you having problems now? _____________________________________
Last Complete Dental Exam, Date: __________________________________
Last Full Mouth X-Rays, Date: _____________________________________

MEDICAL HISTORY	Y	N
Do you have any CURRENT HEALTH PROBLEMS?		
Are you under a PHYSICIAN'S CARE now?		
For what?		
Have you ever taken Fen-Phen/Redux?		
Have you ever used a BISPHOSPHONATE MEDICATION? (Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva)		
Are you PREGNANT?		
Do you use CIGARS/CIGARETTES, PIPE or CHEWING TOBACCO? (circle)		

Please list CURRENT MEDICATIONS

____
____
____
____
____
____
____

PLEASE ☑YES OR NO OF THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE:

	Y	N		Y	N		Y	N		Y	N
AID/HIV POS			Circulatory Problems			Herpes			Rheumatic/Scarlet Fever		
Anaphylaxis			Cortisone Treatments			Hepatitis			Shingles		
Anemia			Cough (persistent)			High Blood Pressure			Shortness of Breath		
Arthritis (Rheumatism)			Cough up Blood			Jaw Pain			Skin Rash		
Artificial Heart Valves			Diabetes			Kidney Disease/Malfunction			Spina Bifida		
Artificial Joints			Epilepsy			Liver Disease			Stroke		
Asthma			Fainting			Mitral Valve Prolapse			Surgical Implant		
Atopic (Allergy Prone)			Food Allergies			Nervous Problems			Swelling of Feet/Hands		
Back Problems			Glaucoma			Pacemaker/Heart Surgery			Thyroid Disease/Malfunction		
Blood Disease			Headaches			Psychiatric Care			Tobacco Habit		
Cancer			Heart Murmur			Rapid Weight Gain/Loss			Tonsillitis		
Chemical Dependency			Heart Problems			Radiation Treatment			Tuberculosis		
Chemotherapy			Hemophilia			Respiratory Disease			Ulcer/Colitis		

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

Aspirin Local Anesthetic Erythromycin Latex Nitrous Oxide Codeine Penicillin

PATIENT Signature (Parent of Child) ________________________________ Date: ____________________________________

CONSENT

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and the Doctor and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance company will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance. I understand that where appropriate, credit reports may be obtained.

PATIENT Signature (Parent of Child) _____________________________________ Date: ______________________________

DENTIST Signature ____