DENTAL HISTORY

	YES	NO
• DO YOU FEEL PAIN IN ANY OF YOUR TEETH?	☐	☐
• DO YOU CLENCH OR GRIND YOUR TEETH?	☐	☐
• DO YOU HAVE PAIN IN YOUR JAW JOINTS?	☐	☐
• HAVE YOU EVER HAD DIFFICULTY GETTING NUMB WITH LOCAL ANESTHETIC?	☐	☐
• DO YOU REQUIRE SEDATION TO HAVE DENTAL TREATMENT?	☐	☐
• HAVE YOU EVER HAD DIFFICULT EXTRACTIONS IN THE PAST?	☐	☐
• DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	☐	☐
• DO YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING?	☐	☐

MEDICAL HISTORY

PHYSICIAN'S NAME: _____ PHYSICIAN'S PHONE NUMBER: _____

PLEASE LIST ANY SERIOUS ILLNESSES OR MEDICAL PROCEDURES/SURGERIES WITHIN THE PAST 5 YEARS:

_____

_____

_____

(WOMEN) ARE YOU PREGNANT? YES ☐ NO ☐ NURSING? YES ☐ NO ☐ USING BIRTH CONTROL? YES ☐ NO ☐

PLEASE MARK IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING CONDITIONS AND THEN USE THE LINES BELOW TO PROVIDE DETAILS OR TO DESCRIBE ANY OTHER MEDICAL CONDITIONS NOT LISTED.

☐ AIDS/HIV	☐ DIABETES	☐ LUNG DISEASE	☐ TOBACCO USE
☐ ARTIFICIAL HEART VALVES	☐ EPILEPSY	☐ NERVOUS PROBLEMS	☐ ULCER
☐ ASTHMA	☐ FAINTING	☐ PACEMAKER	☐ VENEREAL DISEASE
☐ BACK PROBLEMS	☐ HEART PROBLEMS	☐ PSYCHIATRIC CARE	☐ EXCESSIVE BLEEDING OR TAKING AN ANTICOAGULANT
☐ CANCER	☐ HEPATITIS/LIVER DISEASE	☐ RADIATION TREATMENT	
☐ CHEMICAL DEPENDENCY	☐ HIGH BLOOD PRESSURE	☐ STROKE	
☐ CHEMOTHERAPY	☐ KIDNEY DISEASE	☐ THYROID PROBLEMS	

_____

_____

_____

- ARE YOU TAKING OR HAVE YOU EVER TAKEN BISPHOSPHONATES (SUCH AS FOSAMAX, ACTONEL, BONIVA, AREDIA, ZOMETA, OR RECLAST) FOR OSTEOPOROSIS, OR AS PART OF CHEMOTHERAPY FOR CANCER? YES ☐ NO ☐
- HAVE YOU EVER HAD AN ARTIFICIAL JOINT REPLACEMENT (KNEE, HIP, SHOULDER, ETC)? YES ☐ NO ☐

PLEASE MARK IF YOU HAVE EVER HAD AN ALLERGY OR OTHER BAD REACTION TO THE FOLLOWING:

☐ LOCAL ANESTHETIC ☐ ANTIBIOTICS (SPECIFY WHICH): _____ ☐ PAIN MEDICATION ☐ LATEX

☐ OTHERS: _____

PLEASE LIST ALL MEDICATIONS YOU ARE TAKING:

_____

_____

_____

_____

AUTHORIZATION

- I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT THEY ARE PAID FOR BY INSURANCE.
- If applicable, I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered.
- I authorize the use of this signature on all insurance submissions.
- I authorize the dentist to release all information necessary to secure the payment of any applicable insurance benefits.

SIGNATURE: _____ DATE: _____