MEDICAL& DENTAL HEALTH HISTORY

Do you have, or have you had any of the following?

Heart Problems		Yes	No
Chest Pain			
Shortness of Breath			
Blood Pressure Problem			
Heart Murmur			
Heart Valve Problem			
Taking Heart Medication			
Rheumatic/Scarlet Fever			
Pacemaker			
Artificial Heart Valve			
Blood Problems			
Easy Bruising			
Frequent Nosebleeds			
Abnormal Bleeding			
Blood Disease (anemia)			
Ever require a blood transfusion			
Allergy Problems			
Hay Fever			
Sinus Problems			
Skin Rashes			
Taking Allery Medication			
Asthma			
Intestinal Problems			
Ulcers			
Weight Gain or Loss			
Special Diet			
Constipation/Diarrhea			
Kidney or Bladder Problem			
Bone or Joint Problems			
Arthritis			
Back or Neck Pain			
Joint Replacement (eg: total hip, pins, implants)			
Fainting Spells, Seizures, or Epilepsy			

		Yes	No
Stroke(s)			
Frequent or Severe Headaches			
Thyroid Problems			
Persistent Cough or Swollen Glandes			
Premedication required by physician			
Cancer/Tumor			
Are you allergic, or have you reacted adversely to any of the following?			
Local anesthetic ("Freezing")			
Penicillin or other antibiotics			
Barbiturates, sedatives, sleeping pills			
Aspirin, Acetaminophen, or Ibuprofen			
Codeine, Demerol, or other narcotics			
Reaction to metals			
Latex or rubber dam			
Fluoride			
Other:___________________			
Diabetes			
Urinate more than 6 times a day			
Thirsty or mouth is dry much of the time			
Family history of diabetes			
Tuberculosis or other respiratory disease			
Do you drink alcohol? If so how much? _____________			
Do you smoke? If so how much__________________			
Hepatitis, jaundice, or liver trouble			
Herpes or other STD			
HIV-Positive/AIDS			
Glaucoma			
Do you wear contact lenses			
History of head injury?			
Epilepsy or other neurological disease?			

List of Medications both Prescription and Over the Counter: ____

		Yes	No
History of alcohol or drug abuse?			
Do you have any disease, condition, or problem not listed previously that you feel we should know about? If so, please describe: ___________________________________			
During the past 12 months have you taken any of the following:			
Antibiotics			
Anticoagulants (eg: Coumadin)			
High Blood Pressure Medicine			
Tranquilizers			
Insulin, Orense, or Similar Drug			
Aspirin			
Digitalis or drugs for heart trouble			
Nitroglycerin			
Cortisone (Steroids)			
Natural remedies			
Non-Prescription drug/supplements			
Other: _____________________________			
Women			
Are you taking contraception or other hormones?			
Are you pregnant? If so, expected delivery date: ______________________			
Are you nursing? Have you reached Menopause? If so, do you have any symptoms: _____________________________________			

		Yes	No
Are you apprehensive about dental treatment?			
Have you had problems with previous dental treatment? Do you gag easily? Do you wear dentures? Does food catch between your teeth?			
Do you have difficulty chewing food?			
Do you avoid brushing any part of your mouth because of pain?			
Do you feel twinges of pain when your teeth come into contact with: - Hot foods or liquids? - Cold foods or liquids? - Sours or sweets?			
Do your gums bleed when you brush or floss?			
How often do you brush? ___________ How often do you floss? ____________			
Are you a habitual gum chewer?			
Does the saliva in your mouth seem: Too little? Or Too Much?			
Have you had orthodontic (braces) treatment in the past?			
Would you like to have straighter teeth?			
Have you noticed slow healing sores in or around your mouth?			
Do you experience pain when you chew or open your mouth wide to bite food?			
Do you clench or grind your jaws frequently?			
Do you have temporomandibular (jaw) disorder (TMJ)?			
Are you dissatisfied with the appearance of your teeth?			
Would you like to have whiter teeth?			
Do you notice an unpleasant taste or order in your mouth?			
Do you have sleep problems?			
Are you interested in sedation dentistry?			

Treatment Consent:

I, the undersigned authorize Dental Centre to perform any necessary dental services and oral surgery that I may need during my diagnosis and treatment with my informed consent. I certify that the medical and dental histories provided are accurate and complete to the best of my knowledge. I also understand that any and all dental services are my sole responsibility and that I should make myself aware of any fees associated with my dental care prior to treatment.

_______________________________ _______________________________ ___________________

Signature of Patient/Guardian **Print Name** **Date**

Office Policy:

Your appointment time will be reserved especially for you. If you are unable to keep your scheduled visit, we require a minimum of 2 business days notification. Advance notice allows our office to see other patients who may have been waiting for us for needed treatment. We thank you in advance for your consideration. A charge of $50.00 may apply to your account if sufficient notice is not provided.

YOUR DENTAL PLAN INFORMATION

Primary Plan (For children: the parent who's birth month comes first in the year is the Primary Plan):

Group # __________________________ Insurance Company: ____________________________

Id or Certificate # __________________ Employer/Company Name: _______________________

Subscriber/Policy Holder's Name: ______________________________ DOB: ______________________

Will this plan allow payment to the Dentist? Yes or No

(If your plan will not pay the dentist directly, you are responsible to pay the full amount of your treatment on the day of service)

Basic % of Coverage _______ Major % of Coverage _______ Orthodontic % of Coverage _______

Maximum for Basic: _______ Maximum for Major: _______ Or combined Basic & Major Max _____

Secondary Plan

Group # __________________________ Insurance Company: ____________________________

Id or Certificate # __________________ Employer/Company Name: _______________________

Subscriber/Policy Holder's Name: ______________________________ DOB: ______________________

Will this plan allow payment to the Dentist? Yes or No

(If your plan will not pay the dentist directly, you are responsible to pay the full amount of your treatment on the day of service)

Basic % of Coverage _______ Major % of Coverage _______ Orthodontic % of Coverage _______

Maximum for Basic: _______ Maximum for Major: _______ Or combined Basic & Major Max _____