DENTAL HISTORY

In order to better meet your dental health needs, please take a moment to answer the following:

1. What, if any, dental concerns do you have? _____
2. If you could change anything about your teeth or smile what would it be? _____
3. Date of last: Dental exam _____X-rays _____
4. How often do you brush? _____Floss _____
5. What would you expect from me as a dentist? _____
6. Is it important to you to keep your teeth for a lifetime? _____

Mark (X) if you have had any of the following:

__Bad Breath	__Grinding or clenching teeth	__Sensitivity to hot
__Bleeding Gums	__Loose teeth or broken fillings	__Sensitivity to cold
__clicking or popping jaw	__ periodontal treatment	__Sensitivity to sweets
__Food collection between teeth	__sores or growths in mouth	__Sensitivity when biting

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, you mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Have you ever taken any of the group of drugs collectively referred to as "fen-phen? These include combinations of Lonimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). _Yes _No

Have you had any serious illness or operations? _Yes _No if yes, please explain _____

Have you ever had a blood transfusion? _Yes _No if yes, please give approximate date _____

Check (X) If you have or have had any of the following:

_Anemia	_ Congenital Heart Lesions	_ Hepatitis	_ Scarlet Fever
_ Arthritis, Rheumatism	_ Cortisone Treatments	_Hernia Repair	_ Shortness of Breath
_Artificial Heart Valves	_ Cough, Persistent	_High Blood Pressure	_ Skin Rash
_ Artificial Joints, Pins, etc.	_Cough up Blood	_HIV/AIDS	_ Stroke
_Asthma	_ Diabetes	_Jaw Pain	_ Swelling of Feet or Ankles
_ Back Problems	_Epilepsy	_Kidney Disease	_Thyroid Problems
_ Bleeding Abnormally	_Fainting	_Liver Disease	_ Tobacco Habit
_ Blood Disease	_Glaucoma	_Mitral valve Prolapse	_ Tonsillitis
_ Cancer	_ Headaches	_ Pacemaker	_ Tuberculosis
_ Chemical Dependency	_ Heart Murmur	_ Radiation Treatment	_ Ulcer
_Chemotherapy	_ Heart Problems	_ Respiratory Disease	_ Venereal Disease
_ Circulatory Problems	_ Hemophilia	– Rheumatic Fever	

List medications, supplements you are currently taking:

_____
_____
_____

Allergies:

_____
_____
_____

AUTHORIZATION AND RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

The above-named dentist may use my health care information and may disclose such information to the above-named insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN OR PERSONAL REPRESENTATIVE _____DATE_____