DENTAL HISTORY

Patient _____

Are you having any discomfort at this time? _____

What was completed at your last dental visit? _____ Did you have x-rays? _____

Have you lost any teeth? _____ Why? _____ Any complications? _____

Do you have any of the following? Fixed bridge ___ Partial denture _____ Denture _____

Do you have or have you had any of the following, in relation to a dental visit or everyday dental care?

_____	Fainting	_____	Chronic Headaches
_____	Allergic Reactions	_____	Grinding or Clenching
_____	Abnormal Bleeding	_____	Pain or Clicking in Jaw or Ears
_____	Periodontal Disease (Pyorrhea)	_____	Jaw Soreness
_____	Bleeding Gums	_____	Growths or Sores in Mouth
_____	Food Catching in Teeth	_____	Abscess
_____	Shifting or Looseness of Teeth	_____	Toothache
_____	Hot/Cold or Pressure Sensitive Teeth	_____	Bad Breath

If you have checked any of the above, please explain: _____

_____

Please note any dental problems you are currently having, or any specific reason for your visit other than a regular check up:

_____

How often do you brush? _____ How often do you floss? _____

How do you feel about the condition of your teeth? _____

Do you have any fear of having dentistry done? _____

Would you desire to be tranquilized before dental treatment (ie: nitrous oxide)? _____

MEDICAL HISTORY

Do you have or have you had any of the following? Please indicate with a (✓):

_____	Heart Problems	_____	Malignancies
_____	Heart Murmur	_____	Psychiatric Care
_____	Heart Valve, Joints, Pacemaker	_____	Herpes
_____	High Blood Pressure	_____	Venereal Disease
_____	Low Blood Pressure	_____	HIV Positive
_____	Rheumatic Fever	_____	AIDS Related Complex
_____	Stroke	_____	Auto Immune Deficiency
_____	Fainting or Convulsions	_____	Any Prosthetic Devices
_____	Tuberculosis	_____	Implants
_____	Asthma	_____	Pins, Plates, Balls, Joint Replacements
_____	Allergies	_____	Women: Are you pregnant? Month _____
_____	Allergies to Medications _____	_____	Headaches
_____	Diabetes	Y N	Have you ever been told to pre-medicate with
_____	Abnormal Bleeding	_____	antibiotics before dental treatment?
_____	Hepatitis (type _____)		

If you checked any of the above, please explain: _____

_____

List all medications you are taking (prescription and over the counter): _____

_____

I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the above information.

Ⓧ _____ Date _____

Signature

FINANCIAL AGREEMENT

After a 60 day grace period, a finance charge of 1.8% will be assessed each month on account balance. In the case of nonpayment of this account, I agree to pay collection costs incurred in attempting to collect on this account.

Ⓧ _____ Date _____

Signature