DENTAL HISTORY

Former dentist (new patients only)_____ Last seen _____

What is your main reason for making this appointment?_____

How can we make your dental visits more comfortable?_____

Are you happy with how your teeth look? _____

MEDICAL HISTORY

Name of physician _____

Are you currently under the care of a physician? _____

If yes, why? _____

List all medications or drugs and dosages that you are presently taking: _____

_____

(Women) Are you pregnant? Yes No If yes, how long? _____

Are you allergic to: Penicillin Yes No Codeine Yes No Latex Yes No

Other _____

Check any of the following you have **had or have at present:**

- ☐ Heart disease
- ☐ Heart murmur
- ☐ Rheumatic fever
- ☐ Congenital heart defects
- ☐ Abnormal blood pressure
- ☐ Ulcers
- ☐ Tuberculosis or lung disease
- ☐ Diabetes
- ☐ Excessive Urination
- ☐ Epilepsy
- ☐ Anemia
- ☐ Thyroid problem
- ☐ Chemical dependency
- ☐ Metal sensitivity
- ☐ Kidney disease
- ☐ Arthritis
- ☐ Fainting spells
- ☐ Jaundice
- ☐ Hepatitis
- ☐ Asthma
- ☐ Sinus trouble
- ☐ Cancer
- ☐ Stroke
- ☐ Glaucoma
- ☐ Radiation
- ☐ Psychiatric care
- ☐ Prosthetic implant
- ☐ Immune compromised

Have you had any other serious illness, hospitalization or accident? Yes No

If yes, please explain _____

Consent:

The undersigned hereby authorizes the dental office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care in connection with (patient name) _____

I further authorize and consent that Doctor choose and employ such assistance as he deems fit.

I hereby authorize payment to the Dental Office of the group insurance benefits otherwise payable to me and I authorize the Dental Office to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals. I understand that responsibility for all costs of dental treatment provided in this dental office for myself and my dependents is mine due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1-1/2% finance charge (18% annually) will be added to any balance over 90 days. In the event of default I (we) provide to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient signature _____ Date_____

Parent or Responsible Party _____ Relationship to Patient _____

Recorded by _____