

MEDICAL/DENTAL HISTORY

Family Dentist _____ Address _____ Date of last dental visit _____

Is the Patient under a physician's care? YES NO If yes, for what? _____

List any medications now being taken _____ For what reason? _____

List allergies to any medications _____

Approximately how much has Patient grown in the last year? _____ Has Patient reached puberty? YES NO
(Boys – voice changing; Girls – menstruating)

Has the Patient been diagnosed or treated for any of the following? (Check all that apply.)

- | | | | | |
|--|--|---|---|---------------------------------------|
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Lung Disorders | <input type="checkbox"/> Bone Disorders | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Abnormal Blood Pressure | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> AIDS/HIV Pos | <input type="checkbox"/> Seizures | <input type="checkbox"/> Other _____ | |

YES NO SOMETIMES

Does the Patient require medication before dental visits?

YES NO

Does the Patient have a latex allergy?

YES NO

Does the Patient have a persistent thumb or finger habit?

YES NO

Is the Patient a mouth-breather?

YES NO

Does the Patient vomit, gag, or faint easily?

YES NO

Does the Patient experience headaches or neck aches, especially under stress?

YES NO SOMETIMES

Does the Patient grind or clench the teeth?

YES NO SOMETIMES

Has the Patient had any injuries involving the jaw or teeth?

YES NO

Has the Patient experienced any pain, popping or locking of the jaw?

YES NO

Has the Patient ever been evaluated regarding a jaw problem?

YES NO

Has the Patient been treated for periodontal disease or has treatment been recommended?

YES NO

Is Patient missing any permanent teeth?

YES NO

Does Patient have any extra permanent teeth?

YES NO

Has Patient had any teeth removed by extraction?

YES NO

Is Patient adopted? At what age? _____

Is Patient/Parent aware that appointments will infringe on work/school?

YES NO

SIGNATURE _____ **DATE** _____

Patient (If Minor, Custodial Parent/Legal Guardian)

RELEASE & AUTHORIZATION

Signature of Patient or Parent/Guardian if Patient is a minor

I authorize the release of any information necessary to process my insurance claim, or to communicate with other doctors who may be involved in patient care.

X _____ Date _____

I hereby authorize payment to the dentist of the insurance benefits otherwise payable to me. A copy of this signature is as valid as the original.

X _____ Date _____

I understand I am responsible for any amount not covered by the insurance. I agree to pay for attorney fees and other costs of collection in the event it becomes necessary to use attorney services to secure payment of this account.

X _____ Date _____

MEDICAL HISTORY UPDATE

Has there been any change in Patient's health status since the last visit?

No Yes – please explain

X _____ Date _____

Has there been any change in Patient's health status since the last visit?

No Yes – please explain

X _____ Date _____

Has there been any change in Patient's health status since the last visit?

No Yes – please explain

X _____ Date _____