

Do you have a history of alcohol or chemical dependency or emotional disorder that may affect your treatment? _____ If yes, please explain: _____

Medical History

Please circle to indicate which of the following you have or currently have:

- | | |
|-------------------------------------|---------------------------|
| Heart Attack | Ulcers |
| Stroke | Acid Reflux |
| Congenital Heart Defect | Swelling of feet or hands |
| Heart/Cardiovascular Disease | Cortisone or steroid use |
| Mitral Valve Prolapse | Thyroid Problems |
| High Cholesterol | Parathyroid Problems |
| High Blood Pressure | Glaucoma |
| Artificial Heart Valve | Emphysema |
| Low Blood Pressure | Asthma |
| Heart Pacemaker | Tuberculosis |
| Artificial joint or Prosthesis | Hay Fever |
| Arthritis | Sinus or Nasal Problems |
| Lupus | Seasonal Allergies |
| Kidney Trouble | Latex Sensitivity |
| Liver Disease | Rheumatism |
| Hepatitis- Type _____ | Cancer- Type _____ |
| Diabetes- Type _____ | Radiation Therapy |
| Abnormal Thirst | Chemotherapy |
| Sickle Cell Disease | Venereal Disease |
| Neurological Disorders | HIV |
| Frequent Headaches/Migraines | AIDS |
| Epilepsy or Seizures | Rashes or Skin Disorders |
| Fainting or Dizzy Spells | Bruise Easily |
| Nervous or Anxiety | Anemia |
| Cold Sores | Abnormal Bleeding |
| Psychiatric/Psychological treatment | Osteoporosis |
| Bipolar Disorder | Hemophilia |
| Autism Spectrum | Depression |
| Cognitive Disabilities | ADHD |

Have you gained or lost more than 10 pounds last year? _____

Please list any other medical conditions not listed: _____

Women: are you...

Pregnant _____ Possibly Pregnant _____

Nursing _____ Taking Birth Control _____

** Taking antibiotics may interfere with the effectiveness of oral contraceptives**

Dental History

What is the main reason for your visit? _____
Are you experiencing any pain at this time? _____
Do you see a dentist regularly for check-ups& cleanings? _____
Do your gums bleed frequently or appear red? _____
Are your teeth sensitive? _____ Sensitive to _____
Have you had braces? _____
Have you had periodontal surgery? _____
Are you missing any teeth? _____ Why? _____
Do you frequently have a bad odor or taste in your mouth? _____
Are you satisfied with the appearance of your teeth? _____
Are you satisfied with the current function of your teeth? _____
Do you brush your teeth daily? _____ times per day
Do you floss your teeth? _____ times per day
Do you have dry mouth? _____
Is your jaw frequently sore? _____
Do you grind your teeth? _____
Do you frequently consume sugary or carbonated beverages? _____ times per day
Do you want to keep all of your remaining teeth? _____
Have you ever had an unpleasant dental experience? _____
Please explain: _____
Is there anything else about having dental treatment that you would like us to know?

Acknowledgement of History Questionnaire

I understand that the above information is necessary to provide me with dental care in a safe & efficient manner. I have answered all of the above questions to the best of my knowledge and will notify my doctor of any changes immediately at my next appointment.

Name _____ Date _____

Signature _____

Acknowledgement of Receipt of Notice of Privacy Practices

I have reviewed in its entirety, a copy of the offices notice of privacy practices. Additionally, I may request a copy of the HIPAA document for my records.

Name _____ Date _____

Signature _____



Name: _____

Home Phone: _____ Cell Phone: _____

Address: _____

Birthdate: _____ Email: _____

Social Security Number: _____

Emergency Contact & Number: _____

Whom may we thank for referring you? _____

General Health

Are you currently under the care of a physician? _____ Last Exam: _____

Physician Name: _____ Phone Number: _____

Are you taking any medications? _____ If yes, please list: _____

Do you have any other medications in the past 2 years that you currently aren't taking? If yes, please list: _____

Do you have any allergies? _____ If yes, please list: _____

Have you been hospitalized or had any operations? _____ If yes, please explain what/when: _____

Have you ever had complications with conscious or general anesthesia? _____ If yes, please explain why/when: _____

Do currently smoke cigarettes/tobacco? _____ If yes, _____ packs per day for _____ years.
Have you ever smoked cigarettes/tobacco in the past? _____ When did you quit? _____
Do you use smokeless/chewing tobacco? _____ Do you drink alcohol? _____
Do you use illicit drugs? _____ If yes, please list: _____