

## DENTAL HISTORY

What would you like us to do today \_\_\_\_\_ Are you in dental discomfort today? \_\_\_\_\_

Former Dentist \_\_\_\_\_ Last visit \_\_\_\_\_ Last x-rays \_\_\_\_\_

How often do you brush \_\_\_\_\_ Floss \_\_\_\_\_ Are you happy about the appearance of your teeth? \_\_\_\_\_

Any information we should know about your previous dental treatment \_\_\_\_\_

Place a check mark next to any that apply:

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Bad Breath              | <input type="checkbox"/> Food Collecting between Teeth  | <input type="checkbox"/> Periodontal Treatment | <input type="checkbox"/> Sensitivity to Sweets     |
| <input type="checkbox"/> Bleeding Gums           | <input type="checkbox"/> Grinding or Clenching Teeth    | <input type="checkbox"/> Sensitivity to Cold   | <input type="checkbox"/> Sensitivity when Biting   |
| <input type="checkbox"/> Clicking or Popping Jaw | <input type="checkbox"/> Loose Teeth or Broken Fillings | <input type="checkbox"/> Sensitivity to Hot    | <input type="checkbox"/> Sores or Growths in Mouth |

## MEDICAL HISTORY

Physician's Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Date of last visit \_\_\_\_\_ Have you had any serious illnesses or operations? \_\_\_\_\_ If yes, describe \_\_\_\_\_

Do you have any heart problems \_\_\_\_\_ If yes, describe \_\_\_\_\_

Place a check mark next to any that apply:

- |                                       |  |  |  |  |
|---------------------------------------|--|--|--|--|
| <input type="checkbox"/> Aids         | <input type="checkbox"/> Anemia        | <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Artificial Joints |
| <input type="checkbox"/> Asthma       | <input type="checkbox"/> Cancer        | <input type="checkbox"/> Chemical Dependency   | <input type="checkbox"/> Chemotherapy            | <input type="checkbox"/> Diabetes          |
| <input type="checkbox"/> Epilepsy     | <input type="checkbox"/> Fainting      | <input type="checkbox"/> Headaches             | <input type="checkbox"/> Heart murmur            | <input type="checkbox"/> Herpes            |
| <input type="checkbox"/> Hepatitis    | <input type="checkbox"/> HIV Positive  | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Surgical Implant        | <input type="checkbox"/> Latex Allergy     |
| <input type="checkbox"/> Pacemaker    | <input type="checkbox"/> Jaw Pain      | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Rheumatic fever         | <input type="checkbox"/> Abnormal Bleeding |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tobacco Habit | <input type="checkbox"/> Pregnant              | <input type="checkbox"/> Kidney Disease          |  |

ARE YOU ALLERGIC TO:

Penicillin  Codeine  Local Anesthetic Other Medications? \_\_\_\_\_

List any medications you are currently taking \_\_\_\_\_

Pharmacy Name: \_\_\_\_\_ Phone Number \_\_\_\_\_

## AUTHORIZATION

I verify the above and give my consent for treatment. If there is any change in my medical status, I will inform Dr. Armbruster.

\* PATIENT SIGNATURE \_\_\_\_\_

(If patient is a minor, parent or guardian must sign.)

I authorize payment of my dental benefits directly to my attending dentist for all services, also the use of this signature on all insurance submissions. I authorize my dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges, whether or not paid by insurance.

\* SIGNATURE \_\_\_\_\_