DENTAL HISTORY

Former dentist _____ Address _____ Telephone _____

Date of last dental care _____ Date of last x-rays _____

Please check (√) if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding or clenching teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in mouth

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

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

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐ Yes ☐ No

Any specific problems or discomfort today? _____

Other information about your dental health or previous treatment _____

PLEASE READ AND INITIAL

If you are taking birth control pills, please be advised that some studies have shown them to be **less effective or ineffective** while taking certain antibiotics. Therefore, you should take necessary precautions if this applies to you. _____

In the case of accidental exposure to any body fluids, I, as well as the health care worker, agree to be tested for any infectious diseases which may be transmitted through this exposure. *(state law)* _____

Recent evidence has surfaced that life-threatening results can occur from the interaction of non-prescription drugs, such as cocaine, with the local anesthesia administered in dental treatment. If you are taking ANY medication, prescribed or non-prescribed, it is **ESSENTIAL** that you inform the dentist prior to treatment. _____

AUTHORIZATION

I have reviewed the information on this form and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits.

I hereby consent to treatment and realize that I am fully responsible for the fees related to this treatment. A 12% finance charge will be applied to balance over 60 days past due. In the event my account is in default and is referred to an attorney for collection, I agree to pay attorney's fees of 33⅓% of the unpaid balance at time of referral.

Signature of Patient or Parent/Guardian _____ Date _____

STATUS CHANGES

Date _____	_____	Date _____	_____
Date _____	_____	Date _____	_____
Date _____	_____	Date _____	_____
Date _____	_____	Date _____	_____
Date _____	_____	Date _____	_____

OFFICE USE ONLY