

## Health and Dental Information

Previous Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of last dental exam: \_\_\_\_\_ Last full mouth X-rays: \_\_\_\_\_

### Have you had trouble with any of the following?

Y / N Bad Breath	Y / N Grinding Teeth	Y / N Sensitivity to Heat
Y / N Bleeding Gums	Y / N Loose Teeth or Broken Fillings	Y / N Sensitivity to Cold
Y / N Clicking or Popping Jaw	Y / N Periodontal Treatment	Y / N Sensitivity to Sweets
Y / N Food collection between teeth	Y / N Sores or growths in your mouth	Y / N Sensitivity when Biting

### Have you ever had any of the following?

Y / N AIDS / HIV Positive	Y / N Headaches	Y / N Pacemaker	<b>ALLERGIES</b> Y / N Latex Y / N Penicillin Allergy Y / N Erythromycin Allergy Y / N Codeine Allergy Y / N Aspirin Allergy Y / N Other Drugs Y / N _____ Y / N _____ Y / N <b>Are you Pregnant?</b> Due date: _____
Y / N Anemia	Y / N Heart Disease	Y / N Radiation Treatment	
Y / N Arthritis	Explain _____	Y / N Respiratory Problems	
Y / N Artificial Heart Valve	Y / N Heart Murmur	Y / N Rheumatic Fever	
Y / N Artificial Joints	Y / N Hemophilia	Y / N Scarlet Fever	
Y / N Asthma	Y / N Hepatitis A or B	Y / N Sinus Problems	
Y / N Cancer or Tumors	Y / N High Blood Pressure	Y / N Stomach Problems	
Y / N Circulatory Problems	Y / N Jaw Pain	Y / N Stroke	
Y / N Diabetes	Y / N Kidney Disease	Y / N Thyroid Problems	
Y / N Dizziness or Fainting	Y / N Liver Disease	Y / N Tobacco Habit	
Y / N Drug/Alcohol Addiction	Y / N Mental Disorders	Y / N Tuberculosis	
Y / N Endocarditis (infection)	Y / N Mitral Valve Prolapse	Y / N Ulcers	
Y / N Epilepsy	Y / N Fen-Phen (Diet drug)	Y / N Venereal Disease	

- Do you have or have you had any disease, condition, or problem not listed?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Do you require pre-medication prior to dental treatment?  Yes  No
- Please list any medications currently being taken: \_\_\_\_\_
- Have you ever had any complications following dental treatment or local anesthetic?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Have you been admitted to a hospital or needed emergency care during the past two years?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Are you now under the care of a physician?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

### Authorization

I have reviewed this questionnaire and answered its questions accurately, to the best of my knowledge. I understand that the answers I have provided will be used by the dentist to determine appropriate dental treatment, and I agree to notify the dentist if any changes in my health status should occur.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance **CLEARLY** understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1% per month (12% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.

**I have read the above conditions of treatment and payment and agree to their content.**

\_\_\_\_\_  
Signature of patient, parent or guardian      Date: \_\_\_\_\_      Relationship to Patient: \_\_\_\_\_

\_\_\_\_\_  
Signature of guarantor of payment/responsible party      Date: \_\_\_\_\_      Relationship to Patient: \_\_\_\_\_

\_\_\_\_\_  
Signature of provider      Date: \_\_\_\_\_