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
Stroke
Congenital Heart Defect
Hear/Cardiovascular Disease
Mitral Valve Prolapse
High Cholesterol
High Blood Pressure
Artificial Heart Valve
Low Blood Pressure
Heart Pacemaker
Artificial joint or Prosthesis
Arthritis
Lupus
Kidney Trouble
Liver Disease
Hepatitis- Type _______
Diabetes- Type _______
Abnormal Thirst
Sickle Cell Disease
Neurological Disorders
Frequent Headaches/Migraines
Epilepsy or Seizures
Fainting or Dizzy Spells
Nervous or Anxiety
Cold Sores
Psychiatric/Psychological treatment
Bipolar Disorder
Autism Spectrum
Cognitive Disabilities

Ulcers
Acid Reflux
Swelling of feet or hands
Cortisone or steroid use
Thyroid Problems
Parathyroid Problems
Glaucoma
Emphysema
Asthma
Tuberculosis
Hay Fever
Sinus or Nasal Problems
Seasonal Allergies
Latex Sensitivity
Rheumatism
Cancer- Type ________
Radiation Therapy
Chemotherapy
Venereal Disease
HIV
AIDS
Rashes or Skin Disorders
Bruise Easily
Anemia
Abnormal Bleeding
Osteoporosis
Hemophilia
Depression
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: ____________________________