| | | Office Phone | Date of last exam | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------|
| Are you under medical treatn | nent now? Y N | | | |
| Have you been hospitalized for | or any surgery or serious illness | within the last 5 years? Y N | | |
| If yes, please explain | | | | |
| Are you taking any medicatio | ns, including non-prescription m | edicine? Y N If yes, please list | :: | |
| | | | | |
| Have you ever taken Fosama | x, Boniva, Actonel or any cancer | medications containing bisphospl | nonates? Y N | |
| Are you currently taking Cour | madin, Plavix, Xarelto or any oth | er blood thinners? Y N | | |
| Do you have or have you had | any of the following? | | | |
| High Blood Pressure Y N | Rheumatic Fever Y N | Fainting/Seizures Y N | Respiratory Problems Y N | |
| Asthma Y N | Low Blood Pressure Y N | Epilepsy/Seizures Y N | Diabetes Y N | ř |
| Kidney Diseases Y N | AIDS/HIV Infection Y N | Thyroid Problem Y N | Angina Y N | |
| Heart Disease Y N | Cardiac Pacemaker Y N | Emphysema Y N | Cancer Y N | |
| Hepatitis/Jaundice Y N | Stroke Y N | Hay Fever/Allergies Y N | Tuberculosis Y N | |
| Liver Disease Y N | Other: | | | |
| Are you allergic to or have ha | d any reactions to any antibiotic | s? Please list: | | |
| | | | | |
| Patient Dental | History | | | |
| Name of Previous Dentist and Location | | | Date of Last Exam | |
| Do your gums bleed while bru | ushing or flossing? Y N | Are your teeth sensitive to ho | t or cold? Y N | |
| Are your teeth sensitive to sw | veet or sour liquids/foods? Y | Do you feel pain in any of you | teeth? Y N Have you experienced any difficulty in ch | ewing? |
| De veu have en en en en | : | | | |
| Do you have any sores/lumps | in or near your mouth? Y N | Have you had any head, neck | of jaw injuries? Y N | |
| | ny of the following problems in y | | of jaw injuries? Y N | |
| | | rour jaw? | of jaw injuries? Y N y opening/closing? Y N | |
| Have you ever experienced ar | ny of the following problems in y Pain (joint, ear, side of face)? | rour jaw? | y opening/closing? Y N | |
| Have you ever experienced ar Clicking? Y N | ny of the following problems in y Pain (joint, ear, side of face)? eeth? Y N | your jaw? | y opening/closing? Y N frequently? Y N | |
| Have you ever experienced an Clicking? Y N Do you clench or grind your te Have you had any difficult ext | ny of the following problems in y Pain (joint, ear, side of face)? eeth? Y N | your jaw? Y N Difficult Do you bite your lips or cheeks Have you had any orthodontic | y opening/closing? Y N frequently? Y N | |
| Have you ever experienced an Clicking? Y N Do you clench or grind your te Have you had any difficult ext | ny of the following problems in y Pain (joint, ear, side of face)? eeth? Y N tractions in the past? Y N bleeding following extractions? | your jaw? Y N Difficult Do you bite your lips or cheeks Have you had any orthodontic | y opening/closing? Y N frequently? Y N treatment? Y N | |
| Have you ever experienced and Clicking? Y N Do you clench or grind your to Have you had any difficult extended and prolonged Authorization and Authorizatio | Pain (joint, ear, side of face)? eeth? Y N tractions in the past? Y N bleeding following extractions? | your jaw? Y N Difficult Do you bite your lips or cheeks Have you had any orthodontic Y N Do you wear dentures/ | y opening/closing? Y N frequently? Y N treatment? Y N | |
| Have you ever experienced and Clicking? Y N Do you clench or grind your tell thave you had any difficult extend thave you ever had prolonged Authorization and Clertify that I have read | Pain (joint, ear, side of face)? eeth? Y N tractions in the past? Y N bleeding following extractions? and Release understand the above information | your jaw? Y N Difficult Do you bite your lips or cheeks Have you had any orthodontic Y N Do you wear dentures/ | y opening/closing? Y N frequently? Y N treatment? Y N partials? Y N If so, date of insertion? | |
| Have you ever experienced and Clicking? Y N Do you clench or grind your to thave you had any difficult extended and prolonged Authorization and courately answered. I understand that I have read and courately answered. I understand the courage of | Pain (joint, ear, side of face)? eeth? Y N tractions in the past? Y N bleeding following extractions? and Release understand the above informations. | your jaw? Y N Difficult Do you bite your lips or cheeks Have you had any orthodontic Y N Do you wear dentures/ on to the best of my knowledge and the best of m | y opening/closing? Y N frequently? Y N treatment? Y N partials? Y N If so, date of insertion? | |
| Have you ever experienced and Clicking? Y N Do you clench or grind your to thave you had any difficult extended thave you ever had prolonged Authorization and the certify that I have read and the accurately answered. I understrelease any information includes | Pain (joint, ear, side of face)? eeth? Y N tractions in the past? Y N bleeding following extractions? and Release understand the above informations that providing incorrect integrals the diagnosis and the reconsiding the diagnosis and the reconsidered. | your jaw? Y N Difficult Do you bite your lips or cheeks Have you had any orthodontic Y N Do you wear dentures/ on to the best of my knowledge and formation can be dangerous to make the second of any treatment or examination. | y opening/closing? Y N frequently? Y N treatment? Y N partials? Y N If so, date of insertion? d that the above questions have been y health. I authorize the dentist to | |
| Have you ever experienced and Clicking? Y N Do you clench or grind your to the Have you had any difficult extended the Have you ever had prolonged Authorization and the Country that I have read and the accurately answered. I understrelease any information include the period of such Dental care | Pain (joint, ear, side of face)? eeth? Y N tractions in the past? Y N bleeding following extractions? and Release understand the above informations stand that providing incorrect integral of the diagnosis and the reconsector to third party payors and/or he | your jaw? Y N Difficult Do you bite your lips or cheeks Have you had any orthodontic Y N Do you wear dentures/ on to the best of my knowledge and formation can be dangerous to me ds of any treatment or examination ealth practitioners. I authorize and | y opening/closing? Y N frequently? Y N treatment? Y N partials? Y N If so, date of insertion? Ind that the above questions have been y health. I authorize the dentist to | |
| Have you ever experienced and Clicking? Y N Do you clench or grind your teleave you had any difficult extended and prolonged Authorization and Courties that I have read and Couractely answered. I understrelease any information include the period of such Dental care directly to the dentist or dental care. | Pain (joint, ear, side of face)? eeth? Y N tractions in the past? Y N bleeding following extractions? and Release understand the above informations and that providing incorrect interest in the diagnosis and the record eto third party payors and/or he call group insurance benefits other | Y N Difficult Do you bite your lips or cheeks Have you had any orthodontic Y N Do you wear dentures/ on to the best of my knowledge and formation can be dangerous to my ds of any treatment or examinations ealth practitioners. I authorize and | y opening/closing? Y N frequently? Y N treatment? Y N partials? Y N If so, date of insertion? d that the above questions have been y health. I authorize the dentist to on rendered to me or my child during request my insurance company to pay | |
| Have you ever experienced and Clicking? Y N Do you clench or grind your teleave you had any difficult extended that the you ever had prolonged Authorization and control of the certify that I have read and control of the period of such Dental care directly to the dentist or dental care control of the period of the dentist or dental care control of the period of the dentist or dental care control of the dentist or dental care care care care care care care care | Pain (joint, ear, side of face)? eeth? Y N tractions in the past? Y N bleeding following extractions? and Release understand the above informations and that providing incorrect interest in the diagnosis and the record eto third party payors and/or he call group insurance benefits other | Y N Difficult Do you bite your lips or cheeks Have you had any orthodontic Y N Do you wear dentures/ on to the best of my knowledge and formation can be dangerous to my ds of any treatment or examinations ealth practitioners. I authorize and | y opening/closing? Y N frequently? Y N treatment? Y N partials? Y N If so, date of insertion? d that the above questions have been y health. I authorize the dentist to on rendered to me or my child during request my insurance company to pay d that my dental insurance carrier may | |
| Have you ever experienced and Clicking? Y N Do you clench or grind your to the Have you had any difficult extended the you ever had prolonged Authorization and control of the certify that I have read and control of the period of such Dental care directly to the dentist or dentity pay less than the actual bill for dependents. | Pain (joint, ear, side of face)? Peeth? Y N Practions in the past? Y N Poleeding following extractions? Pand Release Understand the above information of the diagnosis and the record eto third party payors and/or he cal group insurance benefits other services. I agree to be responsi | Y N Difficult Do you bite your lips or cheeks Have you had any orthodontic Y N Do you wear dentures/ on to the best of my knowledge and formation can be dangerous to my ds of any treatment or examinations ealth practitioners. I authorize and | y opening/closing? Y N ifrequently? Y N treatment? Y N partials? Y N if so, date of insertion? d that the above questions have been y health. I authorize the dentist to on rendered to me or my child during request my insurance company to pay d that my dental insurance carrier may indered on my behalf or that of my | |