PATIENT'S DENTAL HISTORY

PATIENT'S NAME	DATE OF BIRTH
REASON FOR THIS VISIT	
WHEN WAS YOUR LAST DENTAL VISIT	WHAT WAS DONE THEN
HOW OFTEN DID YOU VISIT THE DENTIST BEFORE THEN _	
PREVIOUS DENTIST (NAME AND LOCATION)	
HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (>	K-RAYS) TAKEN WHEN/WHERE
HOW OFTEN DO YOU BRUSH YOUR TEETH	HOW OFTEN DO YOU FLOSS YOUR TEETH
IS YOUR DRINKING WATER FLUORIDATED	

YES NO	YES NO
DO YOUR GUMS BLEED WHILE BRUSHING	DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY
OR FLOSSING	HAVE YOU NOTICED ANY LOOSENING OF
ARE YOUR TEETH SENSITIVE TO HOT OR COLD	YOUR TEETH
	DOES FOOD TEND TO BECOME CAUGHT
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR	BETWEEN YOUR TEETH
	HAVE YOU EVER HAD PERIODONTAL
DO YOU FEEL PAIN TO ANY OF YOUR TEETH	
DO YOU HAVE ANY SORES OR LUMPS IN OR	EVER WORN A BITE PLATE OR OTHER APPLIANCE \Box
NEAR YOUR MOUTH	HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS
HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES	IN THE PAST \ldots
HAVE YOU EVER EXPERIENCED ANY OF THE	HAVE YOU EVER HAD ANY PROLONGED BLEEDING
FOLLOWING PROBLEMS IN YOUR JAW?	FOLLOWING EXTRACTIONS
	DO YOU WEAR DENTURES OR PARTIALS
PAIN (JOINT, EAR, SIDE OF FACE)	IF YES, DATE OF PLACEMENT
DIFFICULTY IN OPENING OR CLOSING	HAVE YOU EVER RECEIVED ORAL HYGIENE
	INSTRUCTIONS REGARDING THE CARE OF
DO YOU HAVE FREQUENT HEADACHES	YOUR TEETH AND GUMS
DO YOU CLENCH OR GRIND YOUR TEETH	

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE? _____

AUTHORIZATION AND RELEASE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

Sight.

DATE

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HEALTH HISTORY

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

DOCTOR'S COMMENTS

SIGNATURE

Patterson #051-5775

PATIENT'S NUMBER

DATE

PATIENT'S MEDICAL HISTORY

PATIENT'S NAME

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DATE OF BIRTH __

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATION THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING OUESTIONS.

2. HAVE THERE BEEN ANY CHANGES IN YOUR 13. HAVE YOU EVER TAKEN FOSAMAX, BONIVA, GENERAL HEALTH WITHIN THE PAST YEAR 13. HAVE YOU EVER TAKEN FOSAMAX, BONIVA, ACTONEL OR ANY CANCER MEDICATIONS 13. HAVE YOU EVER TAKEN YARGEN MEDICATIONS ADDRESS 14. HAVE YOU AND RISPHONATES 14. HAVE YOU USE DISALCO			YES	NO		YES	NC
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4. PHYSICIAN'S NAME							
ADDRESS	3.	DATE OF YOUR LAST PHYSICAL EXAM:			CONTAINING BISPHOSPHONATES		
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HEALTH HISTORY

PATIENT'S NUMBER