

Dental History

Patient's Name _____ Date of Birth _____

Reason for Today's Visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check () if you have had problems with any of the following:

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sensitivity to hot |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping of jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores or growths in your mouth |

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

Medical History

Physician's Name _____ Date of Last Visit _____

Have you ever had any serious illnesses or operations? Yes No If yes, describe _____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Check () if you have or have had any of the following:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Herpes | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Emphysema | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Fainting/Dizzy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Gout | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Taking Anticoagulants
(ie: Coumadin, Plavix, etc) |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hay fever | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Headaches | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Congenital Heart Lesion | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Cough up Blood | <input type="checkbox"/> Heart Valve Replacement | <input type="checkbox"/> Radiation Treatment | |

Have you ever had excessive bleeding requiring special treatment? Yes No If yes, describe _____

Have you ever had any other serious illness not checked above? Yes No If yes, describe _____

Medical History continued

Patient's Name _____ Date of Birth _____

MEDICATIONS

List any medications you are currently taking including over the counter medication or dietary supplements.

Write "none" if you are not on any medications or supplements:

ALLERGIES

(Write "none" if you have no known allergies)

I certify that I have answered all questions regarding my medical and dental history to the best of my knowledge. I agree to notify the dental office of any changes in my health or medications.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

Authorization (Please fill out this section if you have dental insurance)

I certify that I, and/or my dependent(s), have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Simply Dental of Lowell all insurance benefits, if any, otherwise payable to me for services rendered.

I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient