

Dental History:

Date Completed : _____

Reason for seeing the Doctor today _____

Date of last Dental Visit _____ Purpose of Visit _____

Last Dental Cleaning _____ Last full mouth x rays _____

Previous Dentist's Name _____ City, State _____

How often do you visit the dentist? _____ How often do you brush/floss? _____

Check any and all that apply:

- Hot or Cold Sensitivity
- Bad Mouth Odors Bad Tastes
- Parents with Gum Disease/Tooth Loss
- Bite Lips or Cheeks Regularly
- Snore
- Difficulty Chewing
- Sensitivity to Sweets
- Frequent Cold Sores/Blisters
- Food Caught Between Teeth
- Mouth Breathe
- Gasp for Air While Sleeping
- Joint Pain
- Sensitivity when Biting or Chewing
- Loose Teeth/Change in Bite
- Clench Jaw or Grind Teeth
- Tired Jaws, Especially in Morning
- Clicking or Popping of Jaw
- Head, Neck, Shoulder Aches

Do you smoke or use tobacco products of any kind? _____ If yes, how frequently? _____

Have you ever had any of the following:

- Orthodontic Treatment—(Braces)
- Serious Injury to Head/Mouth
- Oral Surgery (Teeth Extracted)
- BitePlate/Mouth Guard
- Periodontal Treatment
- Teeth Ground/Bite Adjusted

Medical History:

Have you been under the care of a medical doctor during the past two years for anything other than routine care? _____

If yes, list reasons _____ Physician's Name _____

Physician's Phone _____ Have you been a patient in the hospital during the past five years? _____

Check any and all that apply at the present time, or have applied in the past:

- AIDS
- Artificial Joints
- Diabetes
- Fainting
- Heart Disease
- Jaundice
- Nervous Disorders
- Respiratory Problems
- Stomach Problems
- Ulcers
- Latex Allergy
- Allergies
- Asthma
- Dizziness
- Glaucoma
- Heart Murmur
- Kidney Disease
- Pacemaker
- Rheumatic Fever
- Stroke
- Venereal Disease
- Other _____
- Anemia
- Blood Disease
- Epilepsy
- Hay Fever
- Hepatitis
- Liver Disease
- Pregnancy
- Rheumatism
- Tuberculosis
- Codeine Allergy
- Arthritis
- Cancer
- Excessive Bleeding
- Head Injuries
- High Blood Pressure
- Mental Disease
- Radiation Treatment
- Sinus Problems
- Tumors
- Penicillin Allergy

Please list any and all medications you are currently taking _____

Are you aware of any allergic or adverse reaction to any medication or substance in the past _____

Do you have or have you had any disease, condition or problem not listed above? _____

Women: Are you currently pregnant _____, Number of Months _____ Are you Nursing? _____

I understand the information on this form is necessary to provide me with dental care in a safe and efficient manner. I have provided the information to the best of my knowledge and if there is ever a change in my health, I will inform this office without fail at my next appointment.

Patient Signature _____ Date _____

Signature of Parent/Guardian: _____ Date _____

Other Disclosure and Uses

Notification

Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with Family

Using our best judgment, we may disclose to a family member, other relative, close personal friend, or and other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Food and Drug Administration (FDA)

We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation

If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health

As required by law, we may disclose your protected health information to the public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse & Neglect

We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Correctional Institutions

If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement

We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

Health Oversight

Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceeding

We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

Other Uses

Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by a or with your written authorization and you may revoke the authorization as previously provided.

Website

If we maintain a website that provides information about our entity, this Notice will be on the website.