DENTAL HEALTH HISTORY

AND ANESTHESIA CONSENT

Patient Name_____ Birthdate_____

DENTAL HISTORY

Reason for Today's Visit_____Date of last dental care_____

Former Dentist_____Date of last dental Xrays_____

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

Check ☑ if you have problems with any of the following:

☐ Bad Breath	☐ Grinding teeth	☐ Sensitivity to hot
☐ Bleeding Gums	☐ Loose teeth or broken fillings	☐ Sensitivity to sweet
☐ Clicking or popping jaw	☐ Periodontal treatment	☐ Sensitivity when biting
☐ Food Collection between teeth	☐ Sensitivity to cold	☐ Sores or growths in mouth

Check ☑ if you are interested in any of the following:

☐ Whiter Teeth	☐ Night Guard or Retainer	☐ Safe Amalgam Removal
☐ Straighter Teeth	☐ Botox	☐ Help with Sensitivity

MEDICAL HISTORY

Physician's Name_____Date of Last Visit_____

Have you had any serious illnesses or operations?_____If yes, describe_____

History of orthodontics?_____Do you wear a night guard? ☐ YES ☐ NO

Do you now or have you ever taken a Bisphosphonate or any of the following?

Actonal, Fosamax, Somata, Boniva, or Aveda ☐ YES ☐ NO

I understand that local anesthetic is used routinely in most dental treatments and in rare instances patients have had an allergic reaction to the anesthetic, an adverse reaction to the anesthetic, or temporary or permanent injury to nerves and/or blood vessels from the injection. I understand that the injection area(s) may be uncomfortable following treatment and that my jaw may be stiff and sore from holding my mouth open during treatment. **INITIAL**_____

CONTINUE →

MEDICAL HISTORY

Check ☑ if you have past/present problems with any of the following:

- ☐ **Acid Reflux**
- ☐ **Anemia**
- ☐ **Arthritis, Rheumatism**
- ☐ **Artificial Heart Valves**
- ☐ **Artificial Joints**
- ☐ **Asthma**
- ☐ **Blood Disease**
- ☐ **Blood Thinner**
- ☐ **Breathing Problems**
- ☐ **Bruise Easily**
- ☐ **Cancer**
- ☐ **Chemotherapy**
- ☐ **Chest Pain**
- ☐ **Cold sore/Fever Blister**
- ☐ **Congenital Heart Disorder**
- ☐ **Convulsions**
- ☐ **Diabetes**
- ☐ **Drug Addiction**
- ☐ **Emphysema**
- ☐ **Epilepsy or Seizure**
- ☐ **Excessive Bleeding**
- ☐ **Fainting Spells/ Dizziness**
- ☐ **Frequent Cough**
- ☐ **Frequent Diarrhea**
- ☐ **Frequent Headaches**
- ☐ **Glaucoma**
- ☐ **Heart Attack**
- ☐ **Heart Murmur**
- ☐ **Heart Pace Maker**
- ☐ **Heart Disease**
- ☐ **Hemophilia**
- ☐ **Hepatitis A**
- ☐ **Hepatitis B or C**
- ☐ **High Blood Pressure**
- ☐ **High Cholesterol**
- ☐ **HIV/AIDS**
- ☐ **Hives/Rash**
- ☐ **Hypoglycemia**
- ☐ **Irregular Heart Beat**
- ☐ **Kidney Problems**
- ☐ **Leukemia**
- ☐ **Liver Disease**
- ☐ **Low Blood Pressure**
- ☐ **Lung Disease**
- ☐ **Mitral Valve Prolapse**
- ☐ **Pain in Jaw Joints**
- ☐ **Parathyroid Disease**
- ☐ **Psychiatric Care**
- ☐ **Radiation Treatments**
- ☐ **Recent Weight Loss**
- ☐ **Renal Disease**
- ☐ **Rheumatic Fever**
- ☐ **Scarlet Fever**
- ☐ **Shingles**
- ☐ **Sickle Cell Disease**
- ☐ **Sinus Trouble**
- ☐ **Spina Bifida**
- ☐ **Stomach Intestinal Disease**
- ☐ **Stroke**
- ☐ **Swelling of Limbs**
- ☐ **Thyroid Disease**
- ☐ **TMD**
- ☐ **Tobacco Use**
- ☐ **Tonsillitis**
- ☐ **Tuberculosis**
- ☐ **Tumors/Growths**
- ☐ **Ulcers**
- ☐ **Yellow Jaundice**

MEDICATIONS	ALLERGIES
List medication you are currently taking: _____ _____ _____ _____ Pharmacy:_____	☐ Acrylic ☐ Aspirin ☐ Codeine or other Narcotics ☐ Latex ☐ Local Anesthetic ☐ Metal ☐ Penicillin ☐ Other_____

To the best of my knowledge the questions on this form have been answered accurately. I understand that providing incorrect information on this form can be dangerous to my health. It is my responsibility to inform the dental office of any changes in my medical status. This form will be updated every two years.

Signature of Patient, Parent, or Guardian_____Date_____