

MEDICAL HISTORY

Do you have a personal Physician? yes no
Physician's Name _____
Address _____
Street City State Zip
Phone # (____) _____ Date of last visit _____

Your current physical health is? good fair poor
Please explain: _____

Do you smoke or use tobacco in any form? yes no

Are you allergic to any of the following?

- | | | |
|---|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Sedatives |
| <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Jewelry | <input type="checkbox"/> Sulfa Drugs |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Latex | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Dental Anesthetics | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Other |

Please list additional drugs/materials that cause allergic reaction:

For Women: Are you taking birth control pills? yes no
Are you pregnant? unsure yes no
Week # _____ Are you nursing? yes no

Are you taking any of the following?

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Acetaminophen | <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> Insulin/Diabetes Drugs | <input type="checkbox"/> Thyroid Medicine |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Blood Pressure Meds | <input type="checkbox"/> Nitroglycerin | <input type="checkbox"/> Tranquilizers |
| <input type="checkbox"/> Antihistamines | <input type="checkbox"/> Cold Remedies | <input type="checkbox"/> Recreational Drugs | |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Digitalis/Heart Meds | <input type="checkbox"/> Steroids/Cortisone | |

Are you taking any prescription/over-the-counter drugs not listed above? yes no If yes, please list _____

Do you have or have you experienced the following

- | | | | | |
|--|---|--|--|---|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Colitis | <input type="checkbox"/> Headaches | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Congenital Heart Defects | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Sickle Cell |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Lupus | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Artificial Valves | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Persistent Cough | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Herpes | <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Tuberculosis(TB) |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> HIV+/AIDS | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hospitalization | <input type="checkbox"/> Scarlet Fever | |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Seizures | |

DENTAL HISTORY

Why have you come to the dentist today? _____

Are you currently in pain? yes no

Do you require antibiotics before dental treatment? yes no

Have you ever experienced pain in your jaw joint (TMJ)?
 yes no

Do you floss daily? yes no

Type of bristles on your toothbrush? hard med. soft

How long do you use a toothbrush before replacing it? _____

Do you use anything in addition to your toothbrush and floss?

Would you like fresher breath? yes no

Do your gums bleed? yes no

Have you ever had periodontal disease? yes no

Do you have mobility in your teeth? yes no

Are your teeth sensitive to hot, cold or anything else? yes no

Last Dental Visit Date _____

Why did you leave your previous dentist?

What did you like most about any dentist you have seen?

Least? _____

Are you happy with the way your smile looks? yes no

If you could change anything about your smile what would it be? _____

AUTHORIZATIONS

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need. My method of payment will be:

Signature

Date

I certify that I am covered by _____
Insurance Co. and I assign directly to **Dr. Alan Davenport** all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature

Date