Dental

Reason for today's visit_____

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

___Bad breath	___Grinding teeth	____Sensitivity to hot
___Bleeding gums	___Loose teeth or broken fillings	____Sensitivity to sweets
___Clicking or popping jaw	___Periodontal treatment	____Sensitivity when biting
___Food collection between teeth	___Sores or growths in your mouth	____Sensitivity to cold

Have you ever had a root canal?_____Yes _____No

Medical

Please check any and all that apply:

___High Blood Pressure	___Ulcers/Digestive	**Allergies**	**Medications**
___Respiratory/Asthma	___Migraine/Headaches	___Penicillin	___Antibiotic
___Mitral Valve Prolapse	___Epilepsy/Fainting	___Aspirin	___Pain Medicine
___Neurological	___Glaucoma	___Tylenol	___Heart Medicine
___Aids/HIV Infection	___Hepatitis A	___Codeine	___Aspirin
___Anemia/Bleeding	___Hepatitis B, C, other	___Narcotics	___Cortisone/Steroids
___Diabetes/Kidney	___Tumor	___Local Anesthesia	___Blood Thinner
___Herpes	___Alcoholism/Addiction	___Latex	___Blood Pressure
___Thyroid/Hormonal	___Infectious Disease	___Valium/Tranq	___Hormone
___Hypoglycemia	___Venereal Disease	___Nitrous	___Thyroid
___Smoke	___Psychiatric Care	___Food	___Birth Control Pills
___Shortness of Breath	___TMJ	___Sulfa Drugs	___Insulin
___Cancer	___Heart Disease	___Iodine	___Ulcer/Nexium
___Radiation/Chemo	___Heart Murmur/Defect	___Other	___Bone Related
___Tuberculosis	___Pacemaker		___Antidepressants
___Fatigue	___Heart Attack/Stroke	**List Medications**:_____	
___Swelling	___Irregular Heart Beat	_____	
___Prosthetic Implant	___Any Transplant	_____	
___Joint Replacement	___Arthritis	_____	
___Rheumatic Fever			

Are you currently taking or have you previously taken bisphosphonate medications, such as Actonel, Fosamax, Boniva, Aredia, Skelid, Didronel, or Zometa within the past 12 years? ____Yes ____No

Authorization and

I certify that I answered the above information to the best of my knowledge. I have accurately answered the above questions. I understand that providing incorrect information can be dangerous to my health.

I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature_____Date_____