

# Patient Medical History

Physician and Location: \_\_\_\_\_ Office Phone: \_\_\_\_\_ Date of Last Exam: \_\_\_\_\_

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|---|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|----------------------------------|--|---------------------------------|--|-------------|--|--------------|--|-----------|--|--------|--|---------|--|--|--|--|--|------------------|--|-------------------------------------|--|
| <p>1. Are you under medical treatment now? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 Years? <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>If Yes, please explain: _____</p> <p>3. Are you taking any medication(s) including non-prescription medication(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>If Yes, please list: _____</p> <p>4. Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Do you use controlled substances? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Do you have or have you had any of the following?</p> <table border="0" style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <table border="0"> <tr><td>High Blood Pressure</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> <tr><td>Heart Attack</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> <tr><td>Rheumatic Fever</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> <tr><td>Swollen Ankles</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> <tr><td>Fainting / Seizures</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> <tr><td>Asthma</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> <tr><td>Low Blood Pressure</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> <tr><td>Epilepsy / Convulsions</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> <tr><td>Leukemia</td><td><input 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Are you allergic to or have you had any reactions to the following?</p> <table border="0"> <tr><td>Local Anesthetics (ex. Novocain)</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> <tr><td>Penicillin or other antibiotics</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> <tr><td>Sulfa drugs</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> <tr><td>Barbiturates</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> <tr><td>Sedatives</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> <tr><td>Iodine</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> <tr><td>Aspirin</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> <tr><td>Any metals (ex. nickel, mercury, ect.)</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> </table> <p>9. Women Only:</p> <table border="0"> <tr><td>Are you pregnant or think you may be pregnant?</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> <tr><td>Are you nursing?</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> <tr><td>Are you taking oral contraceptives?</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> </table> | Local Anesthetics (ex. 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| High Blood Pressure   | <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |                                 |  |             |  |              |  |           |  |        |  |         |  |  |  |  |  |                  |  |                                     |  |
| Heart Attack  | <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |                                 |  |             |  |              |  |           |  |        |  |         |  |  |  |  |  |                  |  |                                     |  |
| Rheumatic Fever   | <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |                                 |  |             |  |              |  |           |  |        |  |         |  |  |  |  |  |                  |  |                                     |  |
| Swollen Ankles  | <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |                                 |  |             |  |              |  |           |  |        |  |         |  |  |  |  |  |                  |  |                                     |  |
| Fainting / Seizures   | <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |                                 |  |             |  |              |  |           |  |        |  |         |  |  |  |  |  |                  |  |                                     |  |
| Asthma  | <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |                                 |  |             |  |              |  |           |  |        |  |         |  |  |  |  |  |                  |  |                                     |  |
| Low Blood Pressure  | <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |                                 |  |             |  |              |  |           |  |        |  |         |  |  |  |  |  |                  |  |                                     |  |
| Epilepsy / Convulsions  | <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |                                 |  |             |  |              |  |           |  |        |  |         |  |  |  |  |  |                  |  |                                     |  |
| Leukemia  | <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |                                 |  |             |  |              |  |           |  |        |  |         |  |  |  |  |  |                  |  |                                     |  |
| Diabetes  | <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |                                 |  |             |  |              |  |           |  |        |  |         |  |  |  |  |  |                  |  |                                     |  |
| Kidney Diseases   | <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |                                 |  |             |  |              |  |           |  |        |  |         |  |  |  |  |  |                  |  |                                     |  |
| AIDS or HIV Infection   | <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |                                 |  |             |  |              |  |           |  |        |  |         |  |  |  |  |  |                  |  |                                     |  |
| Thyroid Problem   | <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |                                 |  |             |  |              |  |           |  |        |  |         |  |  |  |  |  |                  |  |                                     |  |
| Heart Disease   | <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |                                 |  |             |  |              |  |           |  |        |  |         |  |  |  |  |  |                  |  |                                     |  |
| Cardiac Pacemaker   | <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |                                 |  |             |  |              |  |           |  |        |  |         |  |  |  |  |  |                  |  |                                     |  |
| Heart Murmur  | <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |                                 |  |             |  |              |  |           |  |        |  |         |  |  |  |  |  |                  |  |                                     |  |
| Angina  | <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |                                 |  |             |  |              |  |           |  |        |  |         |  |  |  |  |  |                  |  |                                     |  |
| Frequently Tired  | <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |                                 |  |             |  |              |  |           |  |        |  |         |  |  |  |  |  |                  |  |                                     |  |
| Anemia  | <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |                                 |  |             |  |              |  |           |  |        |  |         |  |  |  |  |  |                  |  |                                     |  |
| Emphysema   | <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |                                 |  |             |  |              |  |           |  |        |  |         |  |  |  |  |  |                  |  |                                     |  |
| Cancer  | <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |                                 |  |             |  |              |  |           |  |        |  |         |  |  |  |  |  |                  |  |                                     |  |
| Arthritis   | <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |                                 |  |             |  |              |  |           |  |        |  |         |  |  |  |  |  |                  |  |                                     |  |
| Joint Replacement or Implant  | <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |                                 |  |             |  |              |  |           |  |        |  |         |  |  |  |  |  |                  |  |                                     |  |
| Hepatitis / Jaundice  | <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |                                 |  |             |  |              |  |           |  |        |  |         |  |  |  |  |  |                  |  |                                     |  |
| Sexually Transmitted Disease  | <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |                                 |  |             |  |              |  |           |  |        |  |         |  |  |  |  |  |                  |  |                                     |  |
| Stomach Troubles / Ulcers   | <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |                                 |  |             |  |              |  |           |  |        |  |         |  |  |  |  |  |                  |  |                                     |  |
| Local Anesthetics (ex. Novocain)  | <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |                                 |  |             |  |              |  |           |  |        |  |         |  |  |  |  |  |                  |  |                                     |  |
| Penicillin or other antibiotics   | <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |                                 |  |             |  |              |  |           |  |        |  |         |  |  |  |  |  |                  |  |                                     |  |
| Sulfa drugs   | <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |                                 |  |             |  |              |  |           |  |        |  |         |  |  |  |  |  |                  |  |                                     |  |
| Barbiturates  | <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |                                 |  |             |  |              |  |           |  |        |  |         |  |  |  |  |  |                  |  |                                     |  |
| Sedatives   | <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |                                 |  |             |  |              |  |           |  |        |  |         |  |  |  |  |  |                  |  |                                     |  |
| Iodine  | <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |                                 |  |             |  |              |  |           |  |        |  |         |  |  |  |  |  |                  |  |                                     |  |
| Aspirin   | <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |                                 |  |             |  |              |  |           |  |        |  |         |  |  |  |  |  |                  |  |                                     |  |
| Any metals (ex. nickel, mercury, ect.)  | <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |                                 |  |             |  |              |  |           |  |        |  |         |  |  |  |  |  |                  |  |                                     |  |
| Are you pregnant or think you may be pregnant?  | <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |                                 |  |             |  |              |  |           |  |        |  |         |  |  |  |  |  |                  |  |                                     |  |
| Are you nursing?  | <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |                                 |  |             |  |              |  |           |  |        |  |         |  |  |  |  |  |                  |  |                                     |  |
| Are you taking oral contraceptives?   | <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |                                  |  |                                 |  |             |  |              |  |           |  |        |  |         |  |  |  |  |  |                  |  |                                     |  |

# Patient Dental History

Name of Previous Dentist and Location: \_\_\_\_\_ Date of Last Exam: \_\_\_\_\_

- |  |  |  |                                 |  |                                  |  |                    |  |   |
|--|--|--|---------------------------------|--|----------------------------------|--|--------------------|--|---|
| <p>1. Do your gums bleed while brushing or flossing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Are your teeth sensitive to hot or cold liquids/foods? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Are your teeth sensitive to sweet/sour liquids/foods? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Do you feel pain to any of your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Do you have sores or lumps in / or near your mouth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Have you had any head, neck or jaw injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Have you ever experienced any of the following problems in you jaw?</p> <table border="0"> <tr><td>Clicking</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> <tr><td>Pain (joint, ear, side of face)</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> <tr><td>Difficulty in opening or closing</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> <tr><td>Difficulty chewing</td><td><input type="checkbox"/> Yes <input type="checkbox"/> No</td></tr> </table> | Clicking   | <input type="checkbox"/> Yes <input type="checkbox"/> No | Pain (joint, ear, side of face) | <input type="checkbox"/> Yes <input type="checkbox"/> No | Difficulty in opening or closing | <input type="checkbox"/> Yes <input type="checkbox"/> No | Difficulty chewing | <input type="checkbox"/> Yes <input type="checkbox"/> No | <p>8. Do you have frequent headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Do you clench or grind your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Do you bite your lips or cheeks frequently? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Have you ever had any difficult extractions? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Have you had any prolonged bleeding following extractions? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. Have you ever had any orthodontic treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>14. Do you wear dentures or partials? <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>If Yes, date of placement _____</p> <p>15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>16. Do you like your smile? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
| Clicking   | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |                                 |  |                                  |  |                    |  |   |
| Pain (joint, ear, side of face)  | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |                                 |  |                                  |  |                    |  |   |
| Difficulty in opening or closing   | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |                                 |  |                                  |  |                    |  |   |
| Difficulty chewing   | <input type="checkbox"/> Yes <input type="checkbox"/> No |  |                                 |  |                                  |  |                    |  |   |

# Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the periods of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or my dependents. If there is anything I do not understand regarding my dental treatment, I will ask someone.

Patient Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to patient (if filled out and signed by representative of patient): \_\_\_\_\_