riease check 🗷 those	boxes for write		ver is <b>YES</b> . If <b>NO</b> , plea ENT'S DENTAL H		. If unsure, pleas	e circle. Thank You
FORMER DENTIST	TERRITOR STORES		-III O DEITIAE II	ioroiti		
FORMER DENTIST:NAME			CITY		PHONE	DATE OF LAST EXAM
Previous Dental Visits:  ☐ Gum Treatment or ☐ Gum Surgery ☐ Were you given a local anesthetic? ☐ Were regular preventive visits made? ☐ Were home cleaning instructions given?		When was last <b>FULL MOUTH</b> X-ray taken?  Date: Location:			☐ Did you have Flouride Treatments? ☐ Do you have a history of dental decay? ☐ Growths or sore spots in your mouth? ☐ Continuous bad breath?	
Tobacco Use:  Do you now or have you ev	er used tobacco proc	ucts?	If you currently use tobacco, a	re you interested in o	quitting ?	□ NO
Do you have a history of:						
☐ Bleeding or swollen gums ?	Mouth brea	thing or snori	ng?	ching or grinding ?	☐ Food catching	in teeth ?
☐ Mouth, tooth, or jaw injury	? TMJ Proble	ms ? (i.e., clicki	ng of popping)	Dental implants?		
Is there any sensitivity in you	r mouth from:					
☐ Heat ?	☐ Heat ? ☐ Cold ?		☐ Breathing ? ☐ Sw		ets?	
<b>表記述: 题: 批选</b> 模		PATIE	NT'S MEDICAL H	ISTORY		
PHYSICIAN:		3 6 8 8 10 10			THE RESERVE OF	
diets, pregnancies, impending	NAME  Allergies/Hives Venereal Disease Heart Problems or surgery Mitral Valve Prolapse Artificial Heart Valve Chest pain Congenital Heart Disease Stroke Joint Replacement Cold Sores/Fever Blisters Heart Murmur Kidney Problems  medical treatment, including:		CITY  Hepatitis Glaucoma Hemophilia Tuberculosis Blood Trans. High Blood Pressure High Cholesterol Heart Pacemaker Emphysema Liver Disease Radiation Treatments Fainting or Dizzy Spel	ls or Infection	PHONE DATE OF LAST EXAM  Psychiatric Treatment Artificial prosthesis (implants) HIV (Human Immunodeficiency Virus) AIDS (Acquired Immune Deficiency Syndrome Nervousness / Anxiety Breast Surgery / Implants Drug or alcohol dependency Cerebral Palsy Birth Control Prescription (antibiotic alert) Bisphosphonates Reflux Anorexia / Bulimia Dry Mouth/Xerostomia Energy Drinks	
or other information you wish	to bring to doctor's a	ttention.	Madiastics	STADIA N.S. O.	NAME OF STREET	
			Medication		Harris Marie Control	
Current:  1  2  3  4  Is patient allergic to:			Reason:			
History Review  I understand that the information given here status. WITH MY INFORMED CONSENT, I AU balance due. If I have insurance, I hereby aut a service charge of 18% annually will be char	e is, to the best of my knowled THORIZE THE DENTAL STAFF thorize my insurance benefits	ge, correct. I also un TO PERFORM ANY N o be paid directly to	NECESSARY DENTAL SERVICE(S) INDICATE the dentist. I also authorize the dentist to	TRICT CONFIDENCE; and it is ED DURING DIAGNOSIS AND release any information requ	TREATMENT. Lunderstand that I.	ffice of any changes in my medical

**Doctor Signature:** 

Date:

Date:

**Patient Signature:**