MEDICAL HISTORY

Have you been under the care of a physician during the past two years? ❑Yes ❑ No

If yes, for what? _____

Physician's name: _____ Phone: _____

Are you taking, or have you ever taken bisphosphonates such as Fosamax, Boniva, Actonel Atelvia, Reclast? ❑ Yes ❑ No

Are you currently taking any prescription or over the counter medications? ❑ Yes ❑ No

If yes, please list name and dosage _____

_____

_____

_____

Are you aware of having an allergic or adverse reaction to any medication or substance? ❑ Yes ❑ No

If yes, please describe _____

Please indicate which of the following you have had, or have at present. Circle Y for Yes, N for No.

Heart Attack ..... Y N	Diabetes..... Y N	Cancer Therapy ..... Y N
Heart Surgery ..... Y N	Tuberculosis..... Y N	Psychiatric/Psychological Care..... Y N
Chest Pain ..... Y N	Asthma ..... Y N	Kidney Trouble ..... Y N
Congenital Heart Disease..... Y N	Liver Disease ..... Y N	Tumors ..... Y N
Heart Murmur ..... Y N	Arthritis, Rheumatism..... Y N	A.I.D.S. ..... Y N
Mitral Valve Problems ..... Y N	Cortisone Medicine..... Y N	H.I.V. Positive ..... Y N
Artificial Heart Valve ..... Y N	Nervous/Anxious ..... Y N	Thyroid Problems..... Y N
Rheumatic Fever ..... Y N	Neurological Disorders..... Y N	Blood Disorders ..... Y N
Heart Pacemaker ..... Y N	Allergies or Hives ..... Y N	Cold Sores/Fever Blisters ..... Y N
High Blood Pressure ..... Y N	Epilepsy or Seizures..... Y N	Indigestion..... Y N
Swollen Ankles ..... Y N	Stroke ..... Y N	Reflu ..... Y N
Ulcers ..... Y N	Sinus Trouble ..... Y N	Sleep Apnea ..... Y N
Hepatitis ..... Y N	Fainting or Dizzy Spells..... Y N	

Do you have or have you had any disease, condition or problem not listed above? ❑ Yes ❑ No

If yes, describe _____

Have you ever been told that you require premedication with antibiotics prior to dental treatment? ❑ Yes ❑ No

Have you ever had a joint replacement? ❑ Yes ❑ No

Date _____

Do you have latex sensitivity? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking Birth Control Pills? ❑ Yes ❑ No

COMMENTS

CONSENT FOR TREATMENT

I understand that the information contained in the dental and medical histories is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. If further information is needed, you have my permission to ask my respective health care provider or agency who may release such information to you. I will notify Dr. Hunt of any changes in my health or medication. The undersigned hereby authorizes Dr. Hunt to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. Upon such diagnosis, I authorize Dr. Hunt to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

Patient Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

DENTAL HISTORY

Welcome to our office. So that we may provide you with the best possible care, please complete both sides of this medical/dental history form. All information is completely confidential.

Previous Dentist _____ Period of Treatment _____

Address _____ Phone _____

Date of last dental visit _____

Frequency of dental care: _____ Regular _____ Periodic _____ Emergency

How would you rate your home care? _____ Good _____ Fair _____ Poor

What is your immediate dental concern? _____

_____

Please circle Yes or No. If yes, please fill in details.

YES NO Are you presently experiencing any dental pain or discomfort? _____

YES NO Have you ever had an upsetting dental experience? _____

YES NO Do you feel nervous about receiving dental treatment? _____

YES NO Is any part of your mouth sensitive to temperature, pressure, or food/drink? _____

YES NO Do you have an unpleasant taste or odor in your mouth? _____

YES NO Do your gums hurt or bleed when you brush or floss _____

YES NO Have you ever been told you have gum disease? _____

YES NO Have you been treated for gum disease? When? _____

YES NO Have your parents experienced gum disease? _____

YES NO Have you lost any teeth? From what cause? _____

YES NO Have you noticed any loose teeth or change in your bite? _____

YES NO Does food catch between your teeth? Where? _____

YES NO Do you have any pain or soreness around your eyes or ears or other parts of your face? _____

YES NO Are you aware of stiff neck muscles? How often? _____

YES NO Do you ever awaken with an awareness of sore teeth or jaw joints? How often? _____

YES NO Are you aware of clenching and/or grinding your teeth? _____

YES NO Are you aware of your jaw clicking or popping while eating or yawning? How often? _____

YES NO Do you have difficulty opening/closing your mouth _____

YES NO Do you have “tension” headaches? How often? _____

YES NO Have you ever had your bite adjusted? When? _____

YES NO Have you ever worn a bite splint or night guard? When? _____

YES NO Have you ever experienced a serious injury to your head or mouth? _____

YES NO Have you ever had orthodontic treatment? When? _____

YES NO Have you ever had oral surgery? When? _____

YES NO Do you smoke or chew tobacco? _____

YES NO Do you snore? _____

YES NO Is your home water supply fluoridated _____

YES NO Are you dissatisfied with the appearance of your teeth/smile? Why? _____

YES NO Do you think your dental disease is active? _____

YES NO Do you want to learn to control your dental disease and retain your teeth? _____

YES NO Are you deeply concerned about the finances required to return your mouth to excellent health _____

Why have you chosen our office for your dental care _____

_____

– Please complete other side –