DENTAL HISTORY

How we can help you today? (Chief Complaint): _____ Former Dentist: _____

Date of last visit: _____ Date of last dental Xrays: _____

Please mark if you have had or currently have any of the following:

- ☐ Bad Breath
- ☐ Snoring
- ☐ Broken teeth/fillings
- ☐ Orthodontic Treatment
- ☐ Food/floss catch between teeth
- ☐ Jaw joint pain/clicking/popping
- ☐ Teeth grinding/clenching
- ☐ Swollen/tender/bleeding gums
- ☐ Periodontal Treatment
- ☐ Dry Mouth
- ☐ Loose teeth
- ☐ Sensitivity to cold/sweets
- ☐ Sensitivity to biting
- ☐ Root Canal Therapy
- ☐ Bumps/Growths

On a scale of 1-10, with 10 being the highest:

How would you rate your current dental health: 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

How important is your dental health to you: 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

Where do you want your dental health to be: 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

If I could change my smile, I would:

☐ Make them whiter ☐ Make them straighter ☐ Close spaces ☐ Replace metal fillings with tooth-colored restorations

☐ Repair chipped teeth ☐ Replace missing teeth ☐ Replace old crowns that don't match ☐ Have a smile makeover

BP: _____

MEDICAL HISTORY

Date/Staff _____

Please check any that apply to you:

- ☐ AIDS/HIV
- ☐ Allergies
- ☐ Anemia
- ☐ Angina (chest pain)
- ☐ Arthritis
- ☐ Artificial valves/joints
- ☐ Sleep Apnea
- ☐ Asthma
- ☐ Blood disease
- ☐ Bruise easily
- ☐ Stroke
- ☐ Smoker
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Cortisone Medication
- ☐ Diabetes
- ☐ Dizziness
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Thyroid Disease
- ☐ Tobacco products
- ☐ Heart Conditions
- ☐ Heart Defect
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HPV
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Tuberculosis
- ☐ Pre-Medicate for visits
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pregnant Currently
- ☐ Radiation treatment
- ☐ Respiratory Problems
- ☐ Seizures
- ☐ Stomach Problems/Ulcers
- ☐ Venereal Disease
- ☐ Other _____

Drug Allergies: ☐Aspirin ☐Codeine ☐Keflex ☐Latex ☐Local anesthetic ☐Penicillin ☐ Sulfa ☐ Iodine ☐Other_____

Physician's Name: _____Physician's Phone Number_____ Date of Last Exam: _____

Are you currently under the care of a physician, if yes please describe _____

Please list any medications and the corresponding reason: _____

_____

_____

CONSENT AND ACKNOWLEDGEMENT (In reference to all patients-please read and sign)

I have reviewed the health information on this form, and have completed it to the best of my knowledge. I understand that this information will be used by the Doctor and his staff to determine appropriate dental treatment for myself or dependant. I understand that all of the information provided will be held in the strictest of confidence. If anything changes regarding my health, it is my responsibility to inform the Doctor and staff accordingly. I authorize Dr. John Sexton to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. I also authorize Dr. John Sexton and his staff to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of dental anesthetic agents embodies a certain risk. I have reviewed the financial policies stated on this form and agree to all terms and conditions. If I have insurance, I authorize my insurance company to pay my benefits to Dr. John Sexton, otherwise payable to me, for services rendered. I authorize Dr. John Sexton and staff to release any and all information necessary to my insurance company, if any, strictly for the purpose of acquiring reimbursement for dental services. I fully understand the responsibility for payment for dental services provided in this office for myself or dependants is mine, due and payable at the time of service.

Patient Signature (parent/guardian of child) _____Date _____