

Dental History

Name _____ Age _____ Date of last exam _____

Former Dentist _____ Date of last dental x-rays _____

Reason for today's visit _____

How often do you brush? _____ How often do you floss? _____

Please check any of the following conditions that apply to you:

- | | | |
|--|---|---|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Ginding teeth | <input type="checkbox"/> Sensitivity to heat |
| <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Sensitivity when biting |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold | <input type="checkbox"/> Sores or growths in your mouth |

Medical History

Physician _____ Date of last visit _____

Please list all medications you are currently taking: _____

Allergies: _____

(Women) Are you pregnant? Yes No Nursing? Yes No Taking birth control pills? Yes No

Check (✓) if you have had any of the following:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cortisone Treatment | <input type="checkbox"/> Hernia Repair | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Arthritis, Rheumatism | <input type="checkbox"/> Cough, Persistent | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Cough up blood | <input type="checkbox"/> HIV Positive | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Bleeding Abnormally | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tobacco Habit |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Nervous Problems | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Describe _____ | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Respiratory Disease | |

Have you ever taken any of these medications?

- | | | | | |
|--------------------------|--|------------------------------------|-----------------------------------|--------------------------------|
| Diet Medications: | <input type="checkbox"/> Dexfenfluramine | <input type="checkbox"/> Fen-phen | <input type="checkbox"/> Pondimin | <input type="checkbox"/> Redux |
| Blood Thinners: | <input type="checkbox"/> Coumadin | <input type="checkbox"/> Warfarin | | |
| Other: | <input type="checkbox"/> Levoxyl | <input type="checkbox"/> Synthroid | | |

Certification & Assignment

To the best of my knowldege, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I and/or my dependent(s), have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to Dr. Stephen M. Buchanan all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Parent, Guardian or Personal Representative

Date

Please print name of Patient, Guardian, or Personal Representative

Relationship to Patient