



**DENTAL HISTORY**

Reason for today visit \_\_\_\_\_ Date of last dental care \_\_\_\_\_  
Former Dentist \_\_\_\_\_ Office Phone ( ) \_\_\_\_\_  
Office Address \_\_\_\_\_

Check if you have had problems with any of the following:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Bad breath              | <input type="checkbox"/> Grinding teeth                 | <input type="checkbox"/> Sensitivity to hot    |
| <input type="checkbox"/> Bleeding gum            | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to cold   |
| <input type="checkbox"/> Clicking or popping jaw | <input type="checkbox"/> Periodontal treatment          | <input type="checkbox"/> Sensitivity to sweet  |
| <input type="checkbox"/> Food trap between teeth | <input type="checkbox"/> Sores or growths in mouth      | <input type="checkbox"/> Sensitivity to biting |

How often do you floss? \_\_\_\_\_ How often do you brush? \_\_\_\_\_

**MEDICAL HISTORY**

Physician's Name \_\_\_\_\_ Date of last visit \_\_\_\_\_ Reason \_\_\_\_\_

Have you had any serious illnesses or operations? No \_\_\_ Yes \_\_\_, please describe \_\_\_\_\_

Have you ever had a blood transfusion? No \_\_\_ Yes \_\_\_, Approximate date \_\_\_\_\_ Reason \_\_\_\_\_

Women,

Are you pregnant? Yes \_\_\_ No \_\_\_ Nursing? Yes \_\_\_ No \_\_\_ Taking birth control pills? Yes \_\_\_ No \_\_\_

Check if you have or have had any of the following:

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Cortisone treatments | <input type="checkbox"/> Hepatitis             | <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/AIDS              | <input type="checkbox"/> Skin Rash               |
| <input type="checkbox"/> Artificial Joints       | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Jaw Paine             | <input type="checkbox"/> Stroke                  |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Kidney disease        | <input type="checkbox"/> Swelling of feet/ankles |
| <input type="checkbox"/> Back problems           | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Liver disease         | <input type="checkbox"/> Thyroid disease         |
| <input type="checkbox"/> Blood disease           | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Lung disease          | <input type="checkbox"/> Tobacco habit           |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tonsillitis             |
| <input type="checkbox"/> Chemical Dependency     | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Tuberculosis            |
| <input type="checkbox"/> Chemotherapy            | <input type="checkbox"/> Heart problems       | <input type="checkbox"/> Radiation treatment   | <input type="checkbox"/> Ulcer                   |
| <input type="checkbox"/> Circulation problems    | <input type="checkbox"/> Hemophilia           | <input type="checkbox"/> Rheumatic fever       | <input type="checkbox"/> Venereal disease        |

**MEDICATIONS**, you are currently taking:

\_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES**

\_\_\_\_\_  
\_\_\_\_\_

**AUTHORIZATION**

I, certify that I and/or my dependent(s), have insurance coverage with \_\_\_\_\_  
and assign directly to HAPPY TOOTH DENTAL CARE 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.

HAPPY TOOTH DENTAL CARE 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 payable for related dental services.

\_\_\_\_\_  
Signature of Patient, Parent or Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Last First Initial

\_\_\_\_\_  
Relationship to Patient