PATIENT DENTAL HISTORY

Nova Dental ASSOCIATES

Patient's Name _____ ❑ Male ❑ Female Date of Birth _____

Reason for this visit _____

When was your last dental visit _____ What was done then _____

How often did you visit the dentist before then _____

Previous dentist (Optional) _____

Have you had a complete series of dental films (x-rays) taken _____ When _____ Where _____

How often do you brush your teeth _____ How often do you floss you teeth _____

Does your drinking water have flouride? YES ❑ NO ❑

	YES	NO
Do your gums bleed while brushing or flossing	❑	❑
Are your teeth sensitive to hot or cold liquids/foods	❑	❑
Are your teeth sensitive to sweet or sour liquids/foods	❑	❑
Do you feel pain to any of your teeth	❑	❑
Do you have any sores or lumps in or near your mouth	❑	❑
Have you had any head, neck or jaw injuries	❑	❑
Have you ever experienced any of the following problems in your jaw?		
Clicking	❑	❑
Pain (Joint, Ear, Side of Face)	❑	❑
Difficulty in opening or closing	❑	❑
Difficulty in chewing	❑	❑
Do you have frequent headaches	❑	❑
Do you clench or grind your teeth	❑	❑

	YES	NO
Do you bite your lips or cheeks frequently	❑	❑
Have you noticed any loosening of your teeth	❑	❑
Does food tend to become caught between your teeth	❑	❑
Have you ever had periodontal treatment (gums)	❑	❑
Ever worn a bite plate or other appliance	❑	❑
Have you ever had any difficult extractions in the past	❑	❑
Have you ever had any prolonged bleeding following extractions	❑	❑
Do you wear dentures or partials	❑	❑
If yes, date of placement _____		
Have you ever received oral hygiene instructions regarding the care of your teeth and gums	❑	❑

If you could change <u>anything</u> about your smile, what would you change? _____

_____

_____

AUTHORIZATON AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____ Date _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

Doctor's Comments _____

_____

_____

SIGNATURE _____ DATE _____

PATIENT ID _____

PATIENT MEDICAL HISTORY

Nova Dental ASSOCIATES

Patient's Name _____ ❑ Male ❑ Female Date of Birth _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

	YES	NO
1. Are you in good health	❑	❑
2. Have there been any changes in your general health within the past year	❑	❑
3. Date of your last physical exam: _____		
4. Physician's name _____ Address _____ Phone No. _____		
5. Are you now under the care of a physician	❑	❑
6. Have you ever been hospitalized for any surgical operation or serious illness Please explain. _____	❑	❑
7. Are you taking any medicine(s)	❑	❑
Including non-prescription medicine	❑	❑
If yes, what medicine(s) are you taking _____		
8. Have you had any abnormal bleeding	❑	❑

	YES	NO
9. Do you bruise easily	❑	❑
10. Have you ever required a blood transfusion	❑	❑
11. Have you had a recent weight loss	❑	❑
12. Have you ever taken Fen-Phen/Redux	❑	❑
13. Do you use tobacco/alcohol	❑	❑
14. Do you or have you used controlled substances	❑	❑
15. Are you wearing contact lenses	❑	❑
16. Has your physician informed you to premedicate for dental procedures?	❑	❑
17. Do you have any disease, condition or problem not listed above that you think I should know about	❑	❑
If yes, what? _____		
WOMEN ONLY:		
Are you pregnant or think you may be pregnant	❑	❑
Are you nursing	❑	❑
Are you taking Birth Control Pills	❑	❑

ARE YOU ALLERGIC TO OR HAVE HAD REACTIONS TO:	Yes	No
Local Anesthetics like Novacaine	❑	❑
Penicillin or other Antibiotics	❑	❑
Sulfa Drugs	❑	❑
Barbiturates, Sedative or Sleeping Pills	❑	❑
Aspirin	❑	❑
Codiene	❑	❑
Any Metals (E.G., Nickel, Mercury, Etc.)	❑	❑
Latex / Rubber / Acrylic	❑	❑
Other (Please List) _____		
DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:		
Rheumatic Heart Disease or Rheumatic Fever	❑	❑
Scarlet Fever	❑	❑
Heart Defects or Heart Murmur	❑	❑
Heart Trouble, Heart Attack, or Angina	❑	❑
Chest Pain	❑	❑
Shortness of Breath	❑	❑
Pacemaker	❑	❑
Heart Surgery/Heart Stints/Valve Replacement	❑	❑
High Blood Pressure	❑	❑
Low Blood Pressure	❑	❑
Congenital Heart Problem	❑	❑
Swelling of Feet, Ankles, Hands	❑	❑
Hepatitis A, B, or C, Jaundice or Liver Disease	❑	❑
Stroke	❑	❑
Sinus	❑	❑
Lung or Breathing Problems	❑	❑
Asthma or Hay Fever	❑	❑
Hives or Skin Rash	❑	❑

	Yes	No
Fainting or Dizzy Spells	❑	❑
Diabetes	❑	❑
AIDS or HIV Infection	❑	❑
Thyroid Problems	❑	❑
Arthritis or Rheumatism	❑	❑
Joint Replacement or Implant	❑	❑
Stomach Ulcer	❑	❑
Kidney Trouble/Dialysis/Transplant	❑	❑
Tuberculosis	❑	❑
Persistent Cough	❑	❑
Cough That Produces Blood	❑	❑
Chemotherapy (Cancer, Leukemia)	❑	❑
Epilepsy or Seizures	❑	❑
Anemia	❑	❑
Glaucoma	❑	❑
Nervousness	❑	❑
Tonsillitis	❑	❑
Tumors	❑	❑
Mental Health Care	❑	❑
Back Problems	❑	❑
Chemical Dependency	❑	❑
Mitral Valve Prolapse	❑	❑
Cortisone Treatment	❑	❑
Cold Sores/Fever Blisters	❑	❑
Hypoglycemia	❑	❑
Eating Disorders	❑	❑
Are you currently taking or have taken Bisphophonates such as Fosamax, Actonel, Boniva (for Osteoporosis or bone loss) or Zometa or chemotherapy for Malignancy?	❑	❑

PATIENT ID _____