

Dental History

Reason for today's visit _____ Former Dentist _____

Date of last dental visit _____ Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following.

Bad breath <input type="checkbox"/> yes <input type="checkbox"/> no	Bleeding gums <input type="checkbox"/> yes <input type="checkbox"/> no	Blisters on lips or mouth <input type="checkbox"/> yes <input type="checkbox"/> no
Dry mouth <input type="checkbox"/> yes <input type="checkbox"/> no	Grinding teeth <input type="checkbox"/> yes <input type="checkbox"/> no	Burning sensation on tongue <input type="checkbox"/> yes <input type="checkbox"/> no
Jaw pain <input type="checkbox"/> yes <input type="checkbox"/> no	Sensitive to hot <input type="checkbox"/> yes <input type="checkbox"/> no	Sensitive to cold <input type="checkbox"/> yes <input type="checkbox"/> no

Do you smoke or use smokeless tobacco? _____ How long? _____ Have you quit? _____ How long ago? _____

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

Health History

Have you ever taken "fen-phen", Pondimin, or Redux? When? _____ How long? _____ Medical screening done? _____

Do you drink alcohol? yes no How often? _____ Has your drinking ever caused you problems? yes no

Have you ever used recreational drugs? yes no Do you currently use drugs? yes no

Have you ever had a serious illness or surgery? _____ What and When? _____

Have you ever had a blood transfusion? _____ When? _____

Place a mark to indicate if you have had any of the following:

<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Sinus Trouble
<input type="checkbox"/> Anemia	<input type="checkbox"/> Fainting of dizziness	<input type="checkbox"/> Nervous Condition	<input type="checkbox"/> Skin Rash
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Special Diet
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Headaches	<input type="checkbox"/> Psychiatric care	<input type="checkbox"/> Stroke
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Radiation treatment	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Respiratory Diseases	<input type="checkbox"/> Tonsillitis
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Hepatitis Type _____	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer	<input type="checkbox"/> Herpes	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> High Blood Pressure		
<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Jaundice		
<input type="checkbox"/> Congenital Heart Disease	<input type="checkbox"/> Kidney Disease		
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Liver Disease	Women: Are you pregnant? <input type="checkbox"/> How many weeks? _____	
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Low Blood Pressure _____	Are you nursing? <input type="checkbox"/>	
		Do you take birth control? _____	

Do you wear contact lenses? _____

List all Medications you are taking

Pharmacy name _____
Pharmacy Phone _____

Allergies

Aspirin _____ Local Anesthetics _____

Barbiturates _____ Penicillin _____

Codeine _____ Sulfa _____

Latex _____ Other _____

Consent for Treatment

By my initials, I hereby consent to and authorize any X-rays, examination, and diagnosis by Dr. Richard M. Freeman. **INITIALS** ____ By this signature below I am authorizing the above Doctor to perform dental surgery, administer anesthetic and provide the dental treatment explained to me in the treatment plan. This signature also verifies my knowledge and understanding of the treatment to be provided. I understand and it has been explained to me that Dentistry, as in all medical treatments, is not an exact science and therefore results of any treatments performed may vary from patient to patient and cannot be guaranteed. I understand that occasionally, additional surgeries, treatments, or therapies may be required following the initial dental treatment and that I am granting my consent for any and all of these procedures by Dr. Freeman, his hygienists, or assistants. Also, by my signature below I hereby certify the correctness and completeness of the medical history information I have provided above. I also understand that I am responsible for any payment of all fees and costs resulting from my treatment. I also understand that certain complex procedures or medications may require additional consent.

Patient or responsible guardian _____ Date _____

Witness _____