12. Do you have a cardiac pacemaker, prosthetic heart valve or prosthetic joint? ..... Yes or No

What do you have _____

13. Are you **allergic** or have you experienced an unusual reaction to any drugs? ..... Yes or No

- ☐ dental anesthetic
- ☐ codeine
- ☐ aspirin
- ☐ latex
- ☐ penicillin
- ☐ erythromycin
- ☐ tetracycline
- ☐ other antibiotics
- ☐ valium
- ☐ demerol
- ☐ barbiturates or sedatives
- ☐ other _____

14. Do you use tobacco? ..... Yes or No

How much? _____

15. Is there a tendency towards any illness in your family? ..... Yes or No

- ☐ diabetes
- ☐ heart trouble
- ☐ other _____

16. Do you have any disease condition, or problem not listed that I should know about? ..... Yes or No

_____

17. Women, Are you pregnant? ..... Yes or No

DENTAL HEALTH HISTORY

Circle Yes or No

1. Why are you visiting our office? _____

_____

_____

2. Has your dental care been:

☐ Regular (yearly) ☐ Intermittent (when necessary) ☐ infrequent (when in pain)

3. How many cleaning appointments have you had in last 10 years?

4. Have you ever had Periodontal care? ..... Yes or No When _____

Orthodontic care? ..... Yes or No When _____

5. Are you dissatisfied with the appearance of your teeth? ..... Yes or No

6. Have you ever experienced any of the following? ..... Yes or No

- ☐ bleeding gums
- ☐ swelling of gums
- ☐ pain or sorness in gums
- ☐ receding gums
- ☐ puss around the teeth
- ☐ loose teeth
- ☐ spaces between teeth
- ☐ drifting of teeth
- ☐ foul odor
- ☐ bad breath or bad taste
- ☐ food packing between teeth
- ☐ high or rough fillings

7. Are your teeth sensitive? ..... Yes or No

If so, to what _____

8. Do you grind or clench your teeth? ..... Yes or No

9. Have you ever had an injury to your face, neck, or jaws? ..... Yes or No

10. Do you suffer from pain in the face, neck, or jaws? ..... Yes or No

11. Are you having pain in your mouth now? ..... Yes or No

12. These statements are true and complete to the best of my knowledge? ..... Yes or No

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of the notice, please request a copy at your first appointment.

_____ _____

Signature of Patient, Parent or Guardian — Date

Please be advised that 24 hour notice if inability to keep your appointment is expected. Otherwise, reasonable fee for time loss will be charged. In addition, we advise all patients to visit a general dentist for decay examination annually.

FOR OFFICE USE ONLY

History: