B. WELL DENTISTRY

Name: ________________________________ **Date:** ________________________________

Dental History

What would you like us to do today? ____
Are you in dental discomfort today? ______
Former Dentist: _________________________
Date of last dental care: _____________Date of last x-rays:_____________
Have you ever had periodontal (Gum) Treatment? NO YES DATE: ___________

- ☐ Bad breath
- ☐ Loose teeth or broken fillings
- ☐ Bleeding gums
- ☐ Sensitivity to hot or cold
- ☐ Clicking or popping jaw
- ☐ Sensitivity to sweets
- ☐ Food collection between teeth
- ☐ Sensitivity when biting
- ☐ Grinding or clenching teeth
- ☐ Sores or growths in mouth

General Health

Physician's name:
____
Phone: ____________________
Date of last visit: ____________
Are you currently under physician care?
NO YES
Explain: ___________________________

Organ transplant NO YES
If yes, describe: ____________________
Type: ___________Date:____________
Aneurysm repair NO YES
Stroke NO YES
Diabetes NO YES
Hypoglycemia NO YES
Kidney Disease NO YES
Sinus infections NO YES
Liver Disease NO YES
Epilepsy/seizure disorder NO YES
Last episode: ______________
Stomach ulcer/acid reflux NO YES
GERD NO YES
Inflammatory Bowel disease NO YES
Adrenal Insufficiency NO YRS
Blood disease/disorder NO YES
Type: _____________________________
Abnormal bleeding NO YES
Thyroid disease NO YES
-Hyper or Hypo?
Autoimmune disease NO YES
Type: _____________________________
Cancer NO YES
Type: _____________________________
Diag. Date: _________
Treatment: __________________________
- Chemotherapy/Radiation Therapy?

Hemophilia NO YES
High Cholesterol NO YES
High/low blood pressure NO YES
Respiratory disease NO YES
Type: _____________________________
Hay fever NO YES
Breathing Problems NO YES

Infectious Diseases

Hepatitis NO YES
Type: _____________________________
Tuberculosis NO YES
HIV/AIDS NO YES
Herpes NO YES

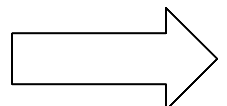
Pre-medicated Conditions

Congenital heart defect NO YES
Joint replacement NO YES
Type: _______Date:_________
Bacterial Endocarditis NO YES
Artificial heart valve NO YES

Heart Health

Rheumatic fever NO YES
Valve damage NO YES
Heart murmur NO YES
Heart Surgery NO YES
Valve repair NO YES
Chest pain NO YES
Angina NO YES
Stent NO YES
Date: ________
Pacemaker NO YES
Date: ________
AICD NO YES
(Automatic Implantable Cardioverter Defibrillator)

CONTINUED ON BACK



Mental/Emotional disorders

Nervousness	NO	YES
Depression	NO	YES
Bipolar	NO	YES
Schizophrenia	NO	YES
Substance abuse	NO	YES
Alzheimer's disease	NO	YES
Dementia	NO	YES
Anorexia nervosa	NO	YES
Bulimia	NO	YES

Past or present? Drug: _________________

Have you ever or do you use tobacco? NO YES

What Type: ___________ How much per day? ___________Length of use: __________ Date quit: ________

Allergies

Latex NO YES

Food NO YES What? _________________________

Drugs NO YES What? _________________________

Other: _____________________

Reaction: __________________

WOMEN: Are you…

Pregnant? NO YES Due Date: ________

Name of OB/GYN: ____________________

Telephone number: ____________________

Please list all medications, vitamins and supplements you are currently taking.
***Prescription and over the counter.**

Hospitalizations/Surgeries? -Please List

Date: Type:

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the signature on all insurance submissions

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature: ____Date: ____________________