

### PATIENT DENTAL HISTORY

Last name:	First:	Middle:	Date of Birth:
Reason for this visit?			
When was your last dental visit?		What was the treatment?	
Previous dentist (Name)			
How often do you brush your teeth?		How often do you floss your teeth?	
Is your drinking water fluoridated?			

	YES	NO		YES	NO
Do your gums bleed while brushing or flossing?			Do you clench or grind your teeth?		
Are your teeth sensitive to hot or cold liquids/foods?			Do you bite your lips or cheeks frequently?		
Are your teeth sensitive to sweet or sour liquids/foods?			Have you noticed any loosening of your teeth?		
Do you feel pain to any of your teeth?			Does food tend to get caught between your teeth?		
Do you have any sores or lumps in or near your mouth?			Have you ever had periodontal (gums) treatment?		
Have you had any head, neck or jaw injuries?			Have you ever worn a bite plate or other appliance?		
Have you ever experienced any of the following problems in your jaw?			Have you ever had difficult extractions in the past?		
Clicking:			Have you had prolonged bleeding following extractions?		
Pain (joint, ear, side of face):			Do you wear dentures or partials?		
Difficulty in opening or closing:			If yes, date of placement:		
Difficulty in chewing:			Have you ever received oral hygiene instructions regarding the care of your teeth and gums?		
Do you have frequent headaches?					

If you could change ANYTHING about your smile, what would you change?

### AUTHORIZATION 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 Mark E. Walker, DDS 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 Mark E. Walker, DDS 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.

Patient/Guardian signature

Date

### PATIENT MEDICAL HISTORY

Patient's name: \_\_\_\_\_ 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 medications that you are taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

		YES	NO			YES	NO
Have there been any changes in your general health within the past year?				Have you had any abnormal bleeding?			
Date of your last physical exam?				Do you bruise easily?			
Physician's name:				Have you ever required a blood transfusion?			
Phone:				Have you had recent weight loss?			
Are you now under the care of a physician?				Do you smoke or use tobacco?			
Have you ever been hospitalized for any surgical operation or serious illness?				Do you or have you used controlled substances?			
Please explain:				Have you ever taken Fosamax, Boniva, Actonel, or any medications containing Bisphosphonates?			
Are you taking any medicines including non-prescriptions?				<b>Women only:</b> Are you pregnant or think you may be?			
Please list:				Are you nursing?			
				Are you taking birth control?			

ARE YOU ALLERGIC OR HAVE REACTIONS TO:	YES	NO			YES	NO
Local anesthetics			Liver disease			
Penicillin			Hepatitis			
Other antibiotics			Stroke			
Codeine/Hydrocodone/Oxycodone			Back problems			
Sulfa drugs			Seasonal allergies, sinus trouble, or hay fever			
Barbiturates, sedatives or sleeping pills			Lung, asthma, or other breathing problems			
Aspirin			Tuberculosis			
Iodine			Fainting or dizzy spells			
Latex or rubber			Diabetes			
<b>DO YOU HAVE OR EVER HAD THE FOLLOWING:</b>	<b>YES</b>	<b>NO</b>	Aids, HIV infection, or sexually transmitted diseases			
Rheumatic heart disease or Rheumatic fever			Thyroid problems – Hyper? or Hypo?			
Scarlet fever			Arthritis – If yes, what type?			
Congenital heart defect			Joint replacement or implant			
Heart condition, heart attack, or angina			Stomach problems or ulcer			
Heart stent			Kidney disease			
If yes, is it medicated?			Parkinson's disease			
Pacemaker			Persistent cough or blood producing cough			
Heart valve replacement			Chemical dependency			
Mitral valve prolapse			Epilepsy or seizures			
High blood pressure			Anemia			
Low blood pressure			Glaucoma			
Tumors/Cancer			Nervousness			
Chemotherapy			Mental health care			
Radiation therapy			Hypoglycemia			
Cortisone treatment			Eating disorders			
Cold sores / Fever blisters			Do you have any disease, condition or problem not listed? Please explain:			