

## **Dental History**

			and the secondary	
Date of last dental care  Date of last dental care  Date of last dental care  Date of last strays  Order(k / ) yes or not if you have had problems with any of the following.  Date of last strays  Order dental problems with any of the following.  Date of last strays  Order dental problems with any of the following.  Date of last strays  Order dental problems with any of the following.  Date of last strays  Order dental problems with any of the following.  Date of last strays  Order dental problems with any of the following.  Date of last strays  Illow do you brush?  Illow do you feel about the appearance of your teeth?  Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure.  We dical History  Physican's name  Date of last strays  Illow do you feel about the appearance of your teeth?  Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure.  We dical History  Physican's name  Date of last strays  We sensitivity to rold  Date of last strays  Illow do you feel about the appearance of your teeth?  Have you ever open can be about your dental health or previous tryatment  We dical History  Physican's name  Phone  P	What would you like us to do today	/?	Are you in dental discomfort to	day?
Check ( / ) yes or no if you have had problems with any of the following   Y   N Food collection between teeth   Y   N Food sensitivity to hot   Y   N Food Sensit	Former Dentist	Address		
Check ( / ) yes or no if you have had problems with any of the following   Y   N Food collection between teeth   Y   N Food Sensitivity to find   Y   N Food Sensitivity	Dentist's Email	Phone		
Check ( / ) yes or no if you have had problems with any of the following   Y   N Food collection between teeth   Y   N Food Sensitivity to find   Y   N Food Sensitivity	Date of last dental care	Date of	last x-rays	
Y   N Read broath     Y   N Food collection between teelt   Y   N Periodontal treatment   Y   N Sensitivity when bitting   Y   N Kernstrivity to fold   Y   N Kernstrivity when bitting   Y   N Kernstrivity to fold   Y   N Kernstrivity when bitting   Y   N Kernstrivity to fold   Y   N Kernstrivity to fold   Y   N Kernstrivity when bitting   Y   N Kernstrivity to fold   Y   N Kernstrivit				
Y   N Breeding gums   Y   N Loose teeth or broken fillings   Y   N Sensitivity to end   Y   N Sensitivity when bitting to the   Y   N Sensitivity when bitting   Y   N Sensitivity when when a water   Y   N Sensitivity when when when we water   Y   N Sensitivity when when when we water   Y   N Sensitivity when when when we water   Y   N Sensitivity when we water   Y	3 /		□ Y □ N Periodontal treatment	☐ Y ☐ N Sensitivity to sweets
How often do you brush?	□Y □ N Bleeding gums	☐ Y ☐ N Grinding or clenching teeth		
How do you feel about the appearance of your teeth?    Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure.   Y   N				
Other information about your dental health or previous treatment    Medical History				
Other information about your dental health or previous treatment    Medical History	How do you feel about the appeara	ance of your teeth?		
Physician's name	Have you ever experienced an adv	verse reaction during or in conjuncti	on with a medical or dental procee	dure2 🔍 Y 🗆 N
Physician's name	Other information about your den	ital health or previous treatment		
Phone Date of last visit				
Phone Date of last visit		Medica	I HISTORY	
If yes, describe  Are you currently under physician care?	Physician's name		Phoné	
Are you currently under physician care?   Y   N   If yes, describe	Date of last visit	Have you had any serious	illnesses or operations? 🔲 Y 🔲 N	
Have you ever had a blood transfusion?   Y   N   Nursing?   Y   N   Taking birth control pills?   Y   N   Women: Are you whether you have had any of the following.				
Have you ever had a blood transfusion?   Y   N   Nursing?   Y   N   Taking birth control pills?   Y   N   Women: Are you whether you have had any of the following.	Are you currently under physician	care? \( \text{Y} \text{ N} \) If yes, describe	%. 4 %	
Have you ever taken Fen-Phen/Redux?	Have you ever had a blood transfu	sion? DV DN If yes give approxin	nate dates	
Check ( / ) yes or no whether you have had any of the following:    Y   N   AlbS/HIV Positive   Y   N   Cough, persistent   Y   N   Shingles   Y   N   Anaphylaxis   Y   N   Cough up blood   Y   N   Kidney disease or malfunction   Y   N   Skin rash   Shortness of breath   Material allergies   Y   N   Skin rash   Shortness of breath   Y   N   Artificial heart valves   Y   N   Fainting   Y   N   Material allergies   Glatex, wool, motel, chemicals   Y   N   Storice   Y   N   Stroke   Y   N   N   N   N   N   N   N   N   N	<i>1</i> 7	Sp.		
Check ( / ) yes or no whether you have had any of the following:    Y   N   AIDS/HIV Positive   Y   N   Cough, persistent   Y   N   N   Anaphylaxis   Y   N   Cough up blood   Y   N   Kidney disease or malfunction   Y   N   Shingles   Y   N   Shingles   Y   N   Anaphylaxis   Y   N   Diabetes   Y   N   Arthritis, Rheumatism   Y   N   Epilepsy   Y   N   Arthritis, Rheumatism   Y   N   Epilepsy   Y   N   Artificial heart valves   Y   N   Fainting   Y   N   Material allergies (latex wool, metal, chemicals)   Y   N   Storke (latex wool, metal, chemicals)   Y   N   Swelling of feet or ankles   Y   N   Swelling of feet or ankles   Y   N   Mitral valve prolapse   Y   N   Swelling of feet or ankles   Y   N   Back problems   Y   N   Heart murmur   Heart murmur   Heart problems   Y   N   Chemotherapy   Y   N   Chemotherapy   Y   N   Hempophilia/ Abnormal bleeding   Y   N   Respiratory disease   Y   N   Tobacco habit   Y   N   Tobacco habit   Y   N   Respiratory disease   Y   N   V   N   Tobacco habit   Y   N   Respiratory disease   Y   N   V   N   Tobacco habit   Y   N   Respiratory disease   Y   N   V   N   Tobacco habit   Y   N   Respiratory disease   Y   N   V   N   Tobacco habit   Y   N   Respiratory disease   Y   N   V   N   Tobacco habit   Y   N   Respiratory disease   Y   N   V   N   Tobacco habit   Y   N   Respiratory disease   Y   N   V   N   Tobacco habit   Y   N   Respiratory disease   Y   N   V   N   Tobacco habit   Y   N   Respiratory disease   Y   N   V   N   Tobacco habit   Y   N   Respiratory disease   Y   N   V   N   Tobacco habit   Y   N   Respiratory disease   Y   N   V   N   Tobacco habit   Y   N   Respiratory disease   Y   N   V   N   Tobacco habit   Y   N   Tobacco habit	·			
Y   N   AlDS/HIV Positive   Y   N   Cough, persistent   Y   N   Jáw pain   Y   N   Shingles   Y   N   Anaphylaxis   Y   N   Cough up blood   Y   N   Kidney disease or malfunction   Y   N   Skin rash   Y   N   Arthritis, Rheumatism   Y   N   Epilepsy   Y   N   Arthritis, Rheumatism   Y   N   Epilepsy   Y   N   Artificial heart valves   Y   N   Fainting   Y   N   Material allergies (latex wool, metal, chemicals)   Y   N   Sturgical implant   Chemicals dependency   Y   N   Asthma   Y   N   Gaucoma   Y   N   Heart murmur   Y   N   Blood disease   Y   N   Heart murmur   Y   N   Blood disease   Y   N   Heart murmur   Y   N   Rapid weight gain or loss   Y   N   Tuberculosis   Y   N   Tuberculosis   Y   N   Tuberculosis   Y   N   Respiratory disease   Y   N   Tuberculosis   Y   N   Respiratory disease   Y   N   Tuberculosis   Y   N   Tuberculosis   Y   N   Respiratory disease   Y   N   Tuberculosis   Y   N   Respiratory disease   Y   N   Tuberculosis   Tuberculosis   Y   N   Tuberculosis   Tuberculo			rth control pills? UY UN	
Y   N   Anaphylaxis   Y   N   Cough up blood   Y   N   Kidney disease or malfunction   Y   N   Shortness of breath   Y   N   Anemia   Y   N   Diabetes   Y   N   Arthritis, Rheumatism   Y   N   Epilepsy   Y   N   Material allergies (latex wool, metal, chemicals)   Y   N   Stroke (latex wool, metal, chemicals)   Y			#	
Y   N   Anemia   Y   N   Diabetes   malfunction   Y   N   Skin rash   Y   N   Arthritis, Rheumatism   Y   N   Epilepsy   Y   N   Liver disease   Y   N   Spina Biffida   Y   N   Artificial heart valves   Y   N   Fainting   Y   N   Material allergies (latex, wool, metal, chemicals)   Y   N   Asthma   Y   N   Glaucoma   Y   N   Mitral valve prolapse   Y   N   Swelling of feet or ankles   Y   N   Back problems   Y   N   Headaches   Y   N   Nervous problems   Y   N   Pacemaker/ Heart surgery   Y   N   Tobacco habit   Tobacco habit   Y   N   Rapid weight gain or loss   Y   N   Repitatric care   Y   N   Repitatric care   Y   N   Repitatric problems   Y   N   Repi		~ .		, S
Y   N   Arthritis, Rheumatism   Y   N   Epilepsy   Y   N   Material allergies (latex, wool, metal, chemicalls)   Y   N   Artificial joints   Y   N   Fainting   Y   N   Material allergies (latex, wool, metal, chemicalls)   Y   N   Artificial joints   Y   N   Glaucoma   Y   N   Mitral valve prolapse   Y   N   Surgical implant   Swelling of feet or ankles   Y   N   Nervous problems   Y   N   Tobacco habit   Y   N   Nervous problems   Y   N   Tobacco habit   Y   N   Radiation treatment   Y   N   Radiation treatment   Y   N   Radiation treatment   Y   N   Respiratory disease   Y   N   Tuberculosis   Y   N   Nervous problems   Y   N   Norvous problems   Y   N   N   Norvous problems   Y   N   N   N   N   N   N   N   N				
Y   N   Artificial heart valves   Y   N   Fainting   Y   N   Artificial heart valves   Y   N   Food allergies (latex wool, metal, chemicals)   Y   N   Asthma   Y   N   Glaucoma   Y   N   Mitral valve prolapse   Y   N   Swelling of feet or ankles   Y   N   Blood disease   Y   N   Heart murmur   Y   N   Pacemaker/ Heart surgery   Pacemaker/ Heart surgery   Psychiatric care   Y   N   Rapid weight gain or loss   Y   N   Respiratory disease   Y   N   Repatitis   Y   N   Respiratory disease   Y   N   Rheumatic/Scarlet fever   Y   N   Rheumatic/Scar				
Y   N   Artificial joints				
Y   N Asthma		3.7		
Y   N Atopic (allergy prone)	•	4-		
Y   N   Nervous problems   Y   N   Thyroid disease or malfunction   Y   N   Pacemaker/   Heart murmur   Y   N   Pacemaker/   Tobacco habit   Tonsillitis   Tuberculosis   Y   N   Chemotherapy   Y   N   Chemotherapy   Y   N   Circulatory problems   Y   N   Hepatitis   Y   N   Respiratory disease   Y   N   Rheumatic/Scarlet fever				
Y   N   Blood disease   Y   N   Heart problems   Heart surgery   Y   N   Tobacco habit   Tonsillitis   Tonsillitis   Tuberculosis   Y   N   Rapid weight gain or loss   Y   N   Respiratory disease   Y   N   N   Respiratory disease   Y   N   N			•	
□ Y □ N Cancer □ Y □ N Chemical dependency □ Y □ N Chemotherapy □ Y □ N Circulatory problems □ Y □ N Cortisone treatments □ Y □ N Cortisone treatments □ Y □ N High blood pressure Is patient currently taking any medications? If yes, list all:    Authorization   Y □ N Rowledge. Lunderstand that this information will be above the best of my knowledge. Lunderstand that this information will be above the best of my knowledge. Lunderstand that this information will be above the best of my knowledge. Lunderstand that this information will be above the best of my knowledge. Lunderstand that this information will be above the best of my knowledge. Lunderstand that this information will be above the best of my knowledge. Lunderstand that this information will be above the best of my knowledge. Lunderstand that this information will be above the best of my knowledge. Lunderstand that this information will be above the best of my knowledge. Lunderstand that this information will be above the best of my knowledge. Lunderstand that this information will be above the best of my knowledge. Lunderstand that this information will be above the best of my knowledge. Lunderstand that this information will be above the best of my knowledge. Lunderstand that this information will be above the best of my knowledge. Lunderstand that this information will be above the best of my knowledge. Lunderstand that this information will be above the best of my knowledge. Lunderstand that this information will be above the best of my knowledge. Lunderstand that this information will be above the best of my knowledge. Lunderstand that this information will be above the best of my knowledge. Lunderstand that this information will be above the best of my had above the best of my	*			
□ Y □ N Chemical dependency □ Y □ N Hemophilia/ Abnormal bleeding □ Y □ N Rapid weight gain or loss □ Y □ N Rapid weight gain or loss □ Y □ N Rapid weight gain or loss □ Y □ N Rapid weight gain or loss □ Y □ N Rapid weight gain or loss □ Y □ N Rapid weight gain or loss □ Y □ N Rapid weight gain or loss □ Y □ N Respiratory disease □ Y □ N Respiratory disease □ Y □ N Rheumatic/Scarlet fever □ Y □ N Venereal disease □ Y □ N Rheumatic/Scarlet fever □ Does patient have drug allergies? If yes, list all: □ Y □ N Venereal disease □ Y □ N N Rapid weight gain or loss □ Y □ N Tuberculosis □ Y □ N Venereal disease □ Y □ N Venereal disease □ Y □ N Rapid weight gain or loss □ Y □ N Rapid weight gain or loss □ Y □ N Rapid weight gain or loss □ Y □ N Venereal disease □ Y □ N Venereal disease □ Y □ N Rapid weight gain or loss □ Y □ N Rapid weight gain or loss □ Y □ N Volcer/Colitis □ Y □ N Venereal disease □ Y □ N Rapid weight gain or loss □ Y □ N Rapid weight gain or loss □ Y □ N Rapid weight gain or loss □ Y □ N Volcer/Colitis □ Y □ N Volcer/Colitis □ Y □ N Venereal disease □ Y □ N Rapid weight gain or loss □ Y □ N Rapid weight gain or loss □ Y □ N Rapid weight gain or loss □ Y □ N Rapid weight gain or loss □ Y □ N Volcer/Colitis □ Y □				🗆 Y 🗎 N - Tobacco habit
Abnormal bleeding  Y N Chemotherapy Y N Circulatory problems Y N Cortisone treatments Y N Respiratory disease Y N Venereal disease Does patient have drug allergies? If yes, list all:  Authorization  Thave reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be		☐ Y ☐ N Hemophilia/		□ Y □ N Tonsillitis
□Y□N Circulatory problems □Y□N Hepatitis □Y□N Respiratory disease □Y□N Rheumatic/Scarlet fever □Y□N Venereal disease □Y□N Venereal disease □Y□N Venereal disease □Y□N Venereal disease □Y□N Rheumatic/Scarlet fever □Y□N Rheumatic/Scarlet fever □Y□N Rheumatic/Scarlet fever □Y□N Rheumatic/Scarlet fever □Y□N Venereal disease □Y□N Venereal disease □Y□N Venereal disease □Y□N Rheumatic/Scarlet fever □Y□N Rheumatic/Scarlet fever □Y□N Rheumatic/Scarlet fever □Y□N Venereal disease □Y□N Venereal disease □Y□N Venereal disease □Y□N Venereal disease	•	Abnormal bleeding		☐ Y ☐ N Tuberculosis
□ Y □ N Cortisone treatments □ Y □ N Hepatitis □ Y □ N Rheumatic/Scarlet fever □ Y □ N Rheumatic/Scarlet fever □ N Venereal disease □ Y □ N Rheumatic/Scarlet fever □ N Venereal disease □ Y □ N Rheumatic/Scarlet fever □ N Venereal disease □ Y □ N Rheumatic/Scarlet fever □ N Venereal disease □ Y □ N Rheumatic/Scarlet fever □ N Venereal disease □ Y □ N Rheumatic/Scarlet fever □ N Venereal disease □ Y □ N Rheumatic/Scarlet fever □ N Venereal disease □ Y □ N Rheumatic/Scarlet fever □ N Venereal disease □ Y □ N Rheumatic/Scarlet fever □ Y □ N Rheumatic/Scarlet fever □ Y □ N Rheumatic/Scarlet fever □ Y □ N Venereal disease □ Y □ N Rheumatic/Scarlet fever □ Y □ N Rheumatic/Scarlet fever □ Y □ N Venereal disease □ Y □ N Rheumatic/Scarlet fever □ Y □ N Rheumatic/Scarlet fever □ Y □ N Rheumatic/Scarlet fever □ Y □ N Venereal disease □ Y □ N Rheumatic/Scarlet fever □ Y □ N Rheumatic/Scarlet f		• 6		
Is patient currently taking any medications? If yes, list all:  Does patient have drug allergies? If yes, list all:  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			The state of the s	☐ Y ☐ N Venereal disease
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		***		
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	Is patient currently taking any med	dications? If yes, list all:	Does patient have drug allergies? I	If yes, list all:
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	3		·	
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				
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			<b>\$</b>	
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				
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		Author Author	rization	

the dentist.

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

 $\label{thm:lambda} \begin{tabular}{ll} Lauthorize the dentist to release all information necessary to secure the payment of benefits. I understand that Lambda financially responsible for all charges whether or not paid by insurance. \\ \end{tabular}$ 

Signature . Date\_