DENTAL HISTORY

What is your chief dental problem? ____

____

YES ( )NO ( ) 1. Do you generally tolerate dental treatment well?
YES ( )NO ( ) 2. Have you ever had a local anesthetic (Novocain) for dental purposes?
YES ( )NO ( ) 3. Have you ever had any reactions to a dental injection?
YES ( )NO ( ) 4. Have you had any prolonged bleeding with extractions in the past?
YES ( )NO ( ) 5. Do you have any unhealed injuries or sores in or around your mouth?
YES ( )NO ( ) 6. Have you been advised on the care of your teeth and gums?
YES ( )NO ( ) 7. Do your gums bleed while brushing?
YES ( )NO ( ) 10. Do you floss? How often? ______________________________
YES ( )NO ( ) 11. Have you had any head, neck, or facial pain?
YES ( )NO ( ) 12. Do you habitually clench or grind your teeth during the day or night?
YES ( )NO ( ) 13. Do you tend to chew on one side only? If so, which side? Left_____ or Right _______
YES ( )NO ( ) 14. Do you have any popping, clicking, or other noises from your jaw joint(s)?
YES ( )NO ( ) 15. How long has it been since your last dental visit? ____________________
X-rays? ______________________Cleaning?____________________
YES ( )NO ( ) 16. Have you ever had Orthodontics (Braces)? When? ______For how long? _________
YES ( )NO ( ) 17. Have you ever had Periodontal (Gum) Surgery? If so when? __________________
YES ( )NO ( ) 18. Other major dental treatment? If so, please explain ______________________

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YES ( )NO ( ) 19. Are you unhappy with your smile or any particular aspect of the way your teeth look or feel? If so, please explain ____________________________________

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I CERTIFY THAT THE ANSWERS GIVEN ARE CORRECT TO THE BEST OF MY KNOWLEDGE. FURTHERMORE, I AUTHORIZE THE RELASE OF ANY MEDICAL AND DENTAL INFORMATION NECESSARY FOR THE COMPLETION OF MY TREATMENT.

______________________________ ______________________

Patient/Guardian Signature Date

MEDICAL HISTORY:

PLEASE ANSWER BY CHECKING YES (Y) OR NO (N) FOR EACH INDIVIDUAL QUESTION

	YES	NO		YES	NO
AIDS/HIV	( )	( )	Jaundice	( )	( )
Anemia	( )	( )	Kidney Disease	( )	( )
Arthritis, Rheumatism	( )	( )	Liver Disease	( )	( )
Artificial Heart Valves	( )	( )	Nervous Problems	( )	( )
Back Problems	( )	( )	Pacemaker	( )	( )
Blood Disease	( )	( )	Psychiatric Care	( )	( )
Cancer	( )	( )	Radiation Treatment	( )	( )
Chemical Dependency	( )	( )	Respiratory Disease	( )	( )
Chemotherapy	( )	( )	Rheumatic Fever	( )	( )
Cortisone Treatments	( )	( )	Scarlet Fever	( )	( )
Cough, persistent or bloody	( )	( )	Sinus Trouble	( )	( )
Diabetes Type: _____	( )	( )	Skin Rash	( )	( )
Emphysema	( )	( )	Stroke	( )	( )
Epilepsy	( )	( )	Swollen Neck Glands	( )	( )
Fainting or Dizziness	( )	( )	Thyroid Problems	( )	( )
Glaucoma	( )	( )	Tonsillitis	( )	( )
Headaches	( )	( )	Tuberculosis	( )	( )
Heart Murmur	( )	( )	Tumor grown on head	( )	( )
Heart Problems	( )	( )	or neck		
Hepatitis Type: _____	( )	( )	Ulcer	( )	( )
Herpes	( )	( )	Venereal Disease	( )	( )
High Blood Pressure	( )	( )	Weight Loss, Unexplained	( )	( )

PLEASE LIST ALL CURRENT MEDICATIONS HERE: ______________________________

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____

ARE YOU ALLERGIC TO OR HAD A BAD REACTION FROM:

	YES	NO		YES	NO
Aspirin	( )	( )	Latex	( )	( )
Barbiturates, Sedatives	( )	( )	Local Anesthetic	( )	( )
Codeine, Narcotics	( )	( )	Penicillin	( )	( )
Iodine	( )	( )	Sulfa	( )	( )

Other allergies or reactions: ____

____

YES ( )NO ( ) 10. Do you have hay fever, frequent skin rashes, etc?
YES ( )NO ( ) 11. Do you use alcohol? How much per day? ____________________
YES ( )NO ( ) 12. Do you smoke? If **YES** how many per day? __________ For how long? ________
YES ( )NO ( ) 13. Are you, or have you been in a drug or alcohol recovery program?

WOMEN

YES ( )NO ( ) 1. Are you taking birth control pills?
YES ( )NO ( ) 2. Are you pregnant, trying to become pregnant or is there, **any chance you might be pregnant?**
YES ( )NO ( ) 3. Are you breast feeding?
YES ( )NO ( ) 4. Are you taking hormonal replacement?

I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL HEALTH HISTORY AND REALIZE THAT INCOMPLETE INFORMATION MAY HAVE AN ADVERSE EFFECT ON MY TREATMENT. TO THE BEST OF MY KNOWLEDGE, THE INFORMATION ABOVE IS COMPLETE AND ACCURATE.

______________________	______________________	______________
Patient/Guardian Signature	Date	Doctor's Initials

Town and Country Dental

12850 Memorial Dr., Ste. 1105
Houston, TX 77024
O: (713)465-6665 F: (713)465-6477

PATIENT INFORMATION

Date: ______/______/______

Patient Name: ____
Last First M.I.

Address: ______________________ City: ____________ State: ______ Zip: ________

Date of Birth: ____________________ Social Security #: ______/______/______

Home Phone: ____________________ Office Phone: ____________________

Cell Phone / Email

☐ I consent to the dental practice using my cell phone number/ email to

☐ **Call** ☐ **Email** regarding appointments and to call regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time.

Cell phone: _ (_____) ________________

Email: ____ ______ (initial)

Marital Status: ☐Single ☐ Married ☐ Widowed ☐Divorced Sex: ☐ Male ☐Female

Physician's Name: __________________________ Physician's Phone: ______________

Address: ______________________________________ Date Last Seen: ____________

WHOM SHOULD WE THANK FOR REFERRING YOU TO US? ________________

In Case of Emergency:

Name: ____________________________ Relationship: ____________________
Address: ____________________ City: ____________ State: ______ Zip: ______
Home Phone: ____________ Office Phone: ____________ Cell Phone: ____________

IF PATIENT IS A MINOR:

Parent/Guardian Name: ______________________ Relationship to Patient: ____________
Home Phone: ____________ Work Phone: ____________ Cell Phone: ____________
Home Address (if different): ____
City: ______________________ State: ________ Zip: ________________
Name of Employer: ____________________ SS#: ____________ Date of Birth: ______
Email Address: ____