INITIAL CLINICAL EXAMINATION

Name:	Name you wished to be called:
Patient Account Number:	Date:

Initial Concern: _____

Date of last Dental Visit	Date of last Dental Cleaning	Date of last X-Rays

1. Do you have any dental problems now?. . . . . ☐Yes ☐No

2. Do you have any teeth sensitive to hot or cold? . . ☐Yes ☐No
   Sweets?. . . .. ☐Yes ☐No

3. Have you ever had?
   a. orthodontic treatment (braces). . . . . ☐Yes ☐No
   b. oral surgery? . . . . . ☐Yes ☐No
   c. periodontal treatment(gum surgery)? . . . . ☐Yes ☐No
   d. your teeth ground or bite adjusted? . . . . . ☐Yes ☐No
   e. worn a bite plate or other appliance?. . . . . ☐Yes ☐No

4. Have you noticed loosening of your teeth?. . . . . ☐Yes ☐No

5. Does food tend to become caught between teeth? ☐Yes ☐No

6. Do you suffer from pain/swelling of gums?. . . . . ☐Yes ☐No

7. Do your gums often bleed when you brush?. . . . ☐Yes ☐No

8. Have your parents experienced gum disease?. . . ☐Yes ☐No

9. Problems of the jaw: Have you ever experienced:
   a. clicking of the jaw? . . . . . ☐Yes ☐No
   b. pain (joint, ear, side of face?). . . . . ☐Yes ☐No
   c. difficulty opening or closing mouth?. . . . ☐Yes ☐No
   d. difficult in chewing? . . . . . ☐Yes ☐No

10. Habits: Do you:
   a. Clench or grind your teeth?. . . . . ☐Yes ☐No
   b. Bite your lips or cheeks regularly?. . . . . ☐Yes ☐No
   c. Hold foreign objects with your teeth such as pencils, pens, nails?. . . . . ☐Yes ☐No
   d. Mouth breath while awake or asleep? . . . . . ☐Yes ☐No
   e. Do you snore? . . . . . ☐Yes ☐No

11. Do you feel nervous about having dental treatment? . . . . . ☐Yes ☐No

12. Have you ever had an upsetting experience in a dental office?. . . . . ☐Yes ☐No

13. Do you expect to eventually lose your teeth?. . . . . ☐Yes ☐No

14. Are you dissatisfied with the appearance of your teeth? . . . . . ☐Yes ☐No
   The alignment?. . . . . ☐Yes ☐No
   The color?. . . . . ☐Yes ☐No

15. Is there anything about dental treatment that bothers you?

Please explain: _____

_____

_____

_____

_____

Patient Signature: _____ Date: _____

Consent:
The undersigned herby authorizes Doctor to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection (name of patient) _____ and further authorization and consent that Doctor choose and employ such as assistance as deemed fit. I also understand the use of anesthetic agents and embodies a certain risk. I understand that responsibility for payment of dental services provided in this office for myself or my dependants is mine, due and payable at time services are rendered unless financial arrangements have been made. I further understand that a 1.75% finance charge will be added to any balance over 60 days. In the event of default I promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note.

Patient Signature: _____ Date: _____ Witness: _____

Parent or Responsible Party: _____ Relationship to patient: _____

HEALTH HISTORY

1. Are you having pain or discomfort at this time?..... **YES** NO
2. Have you been a patient in the Hospital during the past two years?..... **YES** NO
   If yes, please list:_____
   _____ **YES** NO
3. Have you been under the care of a medical doctor during the past two years?..... **YES** **NO**
   Date of your last visit: _____ / _____ / _____ Reason for last visit: _____
   Physician's Name:_____ Phone: (____) _____
   Address: _____ Fax: (____) _____
   City: _____ State: _____ Zip Code: _____
4. Are you now taking any medication, drugs, herbs or pills?..... YES NO

MEDICATIONS

5. List any medications you are currently taking and the correlationg diagnosis:

_____
_____
_____

7. Do you take, or have you taken Phenphen or Redux?..... ☐ YES ☐ NO
8. Have you lost more than 10 pounds in the past year?..... ☐ YES ☐ NO
9. Are you on a special diet?..... ☐ YES ☐ NO
10. Do you take, or have you taken a Bisphosphonate such as Fossmax, Boniva, Actonel, Zometa, Aredia?..... ☐ YES ☐ NO

ALLERGIES

6. Are you allergic or have you reacted adversely to any of the following substance?..... YES NO

Aspirin	Nembutal/Seconal	Novicaine or Xylocaine
Barbiturates (sleeping pills)	Penicillin	Tetracycline
Darvon	Other Antibiotics	Percodan
Codine	Latex	Erythomycin
Demerol	Iodine	Scopolamine
Nitrous Oxide	Sulfa	Valium
Other Antibiotics	Local Anesthectic	Acryllic

Other:_____
_____

11. INDICATE WHICH OF THE FOLLOWING YOU HAVE HAD OR HAVE AT PRESENT CIRLCE "(YES) OR (NO)" TO EACH ITEM.

*Artificial Heart Valves	YES NO	Chronic Cough	YES NO	Mental Retardation	YES NO
*Artificial Joints (hip, knee, etc.)	YES NO	Cortisone Medicine /Treatments	YES NO	Muscular Dystrophy	YES NO
*Congenital Heart Disease	YES NO	Diabetes	YES NO	Multiple Sclerosis	YES NO
*Heart Murmur	YES NO	Down Syndrome	YES NO	Pacemaker	YES NO
*HearSurgery	YES NO	Drug Addiction	YES NO	Pain in Jaw Joints	YES NO
*Lupus	YES NO	Ephysema	YES NO	Psychiatric Treatment	YES NO
*Mitral Valve Prolapse	YES NO	Epilepsy or Seizures	YES NO	Radiation Therapy	YES NO
*Organ Transplant	YES NO	Fainting or Dizzy Spells	YES NO	Respiratory Disease	YES NO
*Rheumatic Fever	YES NO	Glaucoma	YES NO	Scarlet Fever	YES NO
*Rheumatic Heart Disease	YES NO	Hay Fever	YES NO	Sickel Cell Disease	YES NO
*Shunt, Graft Or Fistula	YES NO	Heart Failure	YES NO	Shortness of Breath	YES NO
		Hepatitis A (infectious)	YES NO	Sinus Trouble	YES NO
A.I.D.S	YES NO	Hepatitis B (Infectious)	YES NO	Skin Rash	YES NO
Allergies or Hives	YES NO	Hepatitis C	YES NO	Spinal Cord Injury	YES NO
Angina Pectoris	YES NO	Herpes	YES NO	Stroke	YES NO
Back Problems	YES NO	Hemophilia /Bleed Easily	YES NO	Thyroid Problems	YES NO
Blood Transfusion	YES NO	High Blood Pressure	YES NO	Tuberculosis	YES NO
Bruise Easily	YES NO	H.I.V. POSITIVE	YES NO	Ulcers	YES NO
Cancer	YES NO	Jaundice	YES NO	Venereal Disease	YES NO
Cerebral Palsy	YES NO	Jaw Pain	YES NO	Yellow Jaundice	YES NO
Cold Sores / Fever Blisters	YES NO	Joint Replacement	YES NO		
Chemotherapy	YES NO	Kidney Trouble	YES NO		
Circulatory Problems	YES NO	Liver Disease	YES NO		
Cosmetic Surgery	YES NO	Nervousness	YES NO		

OTHER:_____
_____

12. Do you have or have you had any disease, condition or problem not listed?..... YES NO
    IF YES, PLEASE EXPLAIN BELOW:_____
    _____

13. HEIGHT:	WEIGHT:

14. When you walk up stairsor take a walk, do you ever have to stop because of pain in your chest, shortness of breath, or because you are very tired?..... ☐ YES ☐ NO
15. Do Your Ankles swell during the day?..... ☐ YES ☐ NO
16. Do you use more than two pillows to sleep?..... ☐ YES ☐ NO
17. Do you ever wake from sleep and feel short of breath?..... ☐ YES ☐ NO
18. Has your medical doctor ever said you have cancer or a tumor?... ☐ YES ☐ NO

Pharmacy Name:_____Phone: (_____)_____

FOR WOMEN ONLY:

Are you pregnant?..... ☐ NO ☐ YES, What month? _____
If yes, when is your due date?_____ Are you Nursing? ☐YES ☐ NO
Are you trying to get pregnant?..... ☐ NO ☐ YES, How Long? _____
Are you taking hormones?..... ☐ NO ☐ YES, Name of Medication? _____
Taking birth control pills?..... ☐ NO ☐ YES, Name Of Medication? _____

Note: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills.Consult your physician / gynecologist for assistance regarding additional methods of birth control.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. If I have any changes in my health status or if my medications change, I shall inform the dentist and team at the next appointment without fail.

Patient (Responsible Party/Guardian) Signature: X _____