

About Your Medical History

*for
women*

Are you pregnant?
Are you nursing?
Do you have any problems associated with your menstrual period?
Are you taking oral contraceptives?
Are you undergoing hormonal therapy?

Date
_ / _ / _

YES NO
 YES NO
 YES NO
 YES NO
 YES NO

Date
_ / _ / _

YES NO
 YES NO
 YES NO
 YES NO
 YES NO

*dental
history*

What is your chief dental complaint? _____

Are you experiencing any discomfort or pain at this time?
Are you satisfied with the appearance of your teeth?
Are you able to eat and chew foods satisfactorily?
Do you have headaches, ear aches, or neck pain?
Do you frequently experience sinus problems?
Have you had ANY serious trouble associated with ANY
previous dental treatment?
If YES, please explain

YES NO
 YES NO
 YES NO
 YES NO
 YES NO
 YES NO

YES NO
 YES NO
 YES NO
 YES NO
 YES NO
 YES NO

*other
conditions
not listed*

*general
dental
responsibility
and
consent
statement*

I hereby authorize and request the performance of dental services for myself or for:

I also give my consent to ANY advisable and necessary dental procedures, medications or anesthetics to be administered by the attending dentist or his supervised staff for diagnostic purposes or dental treatment. These records may include study models, photographs, x-rays, and blood studies. I understand and acknowledge that I am financially responsible for the services provided for myself or the above named, regardless of insurance coverage. Treatment plans involving extended credit circumstances are subject to a credit check. I also understand that the treatment estimate presented to me is only an estimate. Occasionally, the need may arise to modify treatment. In such a case, I will be informed of the need for additional treatment, and its fee modifications.

To the best of my knowledge the information in this form is accurate.

Signature of Patient or Guardian

Date

Signature of Witness

Date

Signature of Dentist

Date