Please check any of the following that apply to you. Currently experiencing dental pain/discomfort				DEI	NTA	L HISTORY				
Headaches, earaches, neck pain How much? How long? I any joint pain I could change my smile, I would: I could change my smile, I would change my smile, I would: I could change my smile, I would: I could change my smile, I would make them whiter Close spaces Make them whiter Close spaces Replace old crowns that don't match Replace old crowns that don't	Currently experiencing dental pain/discomfort									N
Please check any of the following that apply to you. Abnormal Bleeding	Do Do Ple	If yes, where Headaches, earaches, neck Jaw joint pain Teeth or filling breaking Grinding or clenching of the Bleeding, swollen or irritate Loose, tipped or shifting the Bad breath. If you have or have you had a Dentures Partial dentures Braces Periodontal (gum) treatme ease share the following date Your last dental cleaning Your last oral cancer scree Your last complete X-rays are of Previous Dentist:	eeth ted greeth my of nts s:	The following?		How much? If I could change my smi Make them whiter Close spaces Replace black metal Repair chipped teeth Replace old crowns that a smile makeout on a scale from 1 10, How important is your de 1 2 3 4 5 6 Where would you rate your 1 2 3 4 5 6 Where do you want your 1 2 3 4 5 6 What is your most import	filling that do ver with ntal he recurred recurred recurred recurred recurred recurred recurred recurred recurred	How long? ould: s with tooth colored restoration't match lo being the highest rating: ealth to you? s 9 10 rent dental health? s 9 10 health to be? s 9 10	ns	N
Please check any of the following that apply to you. Abnormal Bleeding Difficulty Breathing Hepatitis A Radiation Thearpy Alcohol Abuse Difficulty Breathing Hepatitis A Radiation Thearpy Allergies Drug Abuse Hepatitis B Reheumatic Fever Banemia Emphysema Hepatitis C Seizures Carcial Surgery High Blood Pressure Sexually Transmitted Disease Arthritis Facial Surgery High Blood Pressure Sinkle Cell Disease Arthritical Heart Valve Fainting Spells Jaw Joint Pain Sickle Cell Disease Asthma Fever Blisters Jaundice Sinus Problems Blood Transfusion Frequent Headaches Joint Replacement Stroke Bruise Easily Glaucoma Kidney Problems Syhpilis Cancer Gonorrhea Liver Disease Thyroid Problems Chlamydia HIV/AIDS Low Blood Pressure Tuberculosis Chemotherapy Heart Attack Mitral Valve Prolapse Ulcers Colitis Heart Defect Heart Surgery Pregnant (Currently) Do you have any of the following drug allergies? Aspirin Erthromycin Proceam Penicillin Physician's Name: Percodan Penicillin Physician's Name: Percodan Penicillin Physician's Name: Percodan Penicillin Physician's Name: Pretraeycline Latex Please list any medications you are currently taking: Codeine Other:	W	hat did you like <u>most</u> about	your	last dentist?	_	- 				
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Arthritis		Anemia		Emphysema		Hepatitis C		Seizures		
Arthritis		Angina Pectoris		Excessive Bleeding		Herpes		Sexually Transmitted Diseas	se	
Asthma										
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Blood Transfusion Frequent Headaches Joint Replacement Stroke Bruise Easily Glaucoma Kidney Problems Syhpilis Cancer Gonorrhea Liver Disease Thyroid Problems Chlamydia HIV/AIDS Low Blood Pressure Tuberculosis Chemotherapy Heart Attack Mitral Valve Prolapse Ulcers Colitis Heart Murmur Pace Maker Congenital Heart Defect Heart Surgery Pregnant (Currently) Do you have any of the following drug allergies? Are you in currently under the care of a physician? If yes, explain. Nitrous Oxide Valium Physician's Name: Phone: Local Anesthetic Sulfa Phone: Tetracycline Latex Please list any medications you are currently taking: Treatment Authorization Form I hereby authorize and give consent to perform dental services agreed upon between doctor and patient and/or parent or guardian, after thorough explanation and to be necessary and advisable, including any diagnostic aids deemed appropriate by the doctor and the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my dental health and medical condition. Payment for all services rendered are my responsibility.	-	The second contract of				•	-			
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Nitrous Oxide Percodan Penicillin Physician's Name: Phone: Phone: Please list any medications you are currently taking: Treatment Authorization Form I hereby authorize and give consent to perform dental services agreed upon between doctor and patient and/or parent or guardian, after thorough explanation and to be necessary and advisable, including any diagnostic aids deemed appropriate by the doctor and the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my dental health and medical condition. Payment for all services rendered are my responsibility.	Do	you have any of the following	ng dru	ig allergies?						
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Signature (Patient, Parent or Responsible Party): Relationship to Patient: Date:	I he and	reby authorize and give consent to be necessary and advisable, i	to pe	ing any diagnostic aids deer	med app	propriate by the doctor and the	use of	local anesthesia and other medica	ation as	1
	Sign	nature (Patient, Parent or Respon	nsible	Party):	Relationship to P	atient:	Date:			