PATIENT'S MEDICAL HISTORY

ITEM 27011

ALHOLGH DENIAL PERSONNEL PRIMARILY TIESAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOST ENTIRE BODY, HEALTH PROBLEMS HAIP YOU MAY HAVE, OR MEDICATION THAY YOU MAY BE RECEIVING. CHANNES, COLUL HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING OUTSTIONS. 1. ARE YOU IN GOOD HEALTH	PATIENT'S NAME			DATE OF BIRTH		
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2. HAVE THERE BEEN ANY CHANCES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR. 3. DATE OF YOUR LAST PHYSICAL EXAM: 4. PHYSICAN'S NAME ADDRESS PHONE NO. 5. ARE YOU NOW UNDER THE CARE OF A PHYSICALOR. 6. HAVE YOU EVER BEEN HOSPHALIZED FOR ANY SURGICAL OPERATION OR SERIOUS IILLNESS PLEASE EXPLAIN. 7. ARE YOU TAKING ANY MEDICINE(S) INCLUDING NON-PRESCRIPTION MEDICINE IF YES, WHAT MEDICINE(S) ARE YOU TAKING 8. HAVE YOU HAD ANY ABNORMAL BLEEDING. 9. DO YOU BRUISE EASILY. 10. HAVE YOU EVER BECUIRED A BLOOD TRANSFUSION II. HAVE YOU HAD A RECENT WEIGHT LOSS. ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO: LOCAL ANESTHETICS LIKE NOVOCAINE. PENCILIN OR OTHER ANTIBIOTICS. SULTA DRUGS. BABBITURALES, SEDATIVES OR SLEEPING PILLS. BABBITURALES, SEDATIVES OR SLEEPING PILLS. ACIONAL PROJUBERS. 14. HAVE YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ASOVE THAT YOU HINK 15 HOULD KNOW ABOUT. WOMEN ONLY: ARE YOU LALLERGIC TO OR HAVE YOU HAD REACTIONS TO: LOCAL ANESTHETICS LIKE NOVOCAINE. PENCILIN OR OTHER ANTIBIOTICS. BABBITURALES, SEDATIVES OR SLEEPING PILLS. ASPIRIN. BABBITURALES, SEDATIVES OR SLEEPING PILLS. ASPIRIN. BARBITURALES, CLG., NICKEL, MERCURY, ETC.). BARBITURALES, C	1. ARE YOU IN GOOD HEALTH			12. HAVE YOU EVER TAKEN FEN-PHEN/REDUX		A. September 1
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STROKE				CHEMICAL DEPENDENCY		
SINUS TROUBLE	TILL ATTIO, JACKDICE OR LIVER DISEASE	,				
LUNG OR BREATHING PROBLEMS				MITRAL VALVE PROLAPSE		
	STROKE			MITRAL VALVE PROLAPSE		
	STROKE			MITRAL VALVE PROLAPSE		

PATIENT'S DENTAL HISTORY

PATIENT'S NAME			DATE OF BIRTH				
REASON FOR THIS VISIT	····						
			WHAT WAS DONE THEN				
HOW OFTEN DID YOU VISIT THE DENTIST BEFORE TH	IEN	A CALIFORNIA CONTRACTOR AND A CALIFORNIA CONTRACTOR					
			TAKEN WHEN/WHERE				
			HOW OFTEN DO YOU FLOSS YOUR TEETH		W 0		
IS YOUR DRINKING WATER FLUORIDATED	Converte in						
	YES	NO		YES	NO		
DO YOUR GUMS BLEED WHILE BRUSHING			DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY				
OR FLOSSING			HAVE YOU NOTICED ANY LOOSENING OF				
ARE YOUR TEETH SENSITIVE TO HOT OR COLD			YOUR TEETH				
LIQUIDS/FOODS			DOES FOOD TEND TO BECOME CAUGHT				
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR			BETWEEN YOUR TEETH				
LIQUIDS/FOODS			HAVE YOU EVER HAD PERIODONTAL				
DO YOU FEEL PAIN TO ANY OF YOUR TEETH			TREATMENT (GUMS)				
DO YOU HAVE ANY SORES OR LUMPS IN OR			EVER WORN A BITE PLATE OR OTHER APPLIANCE.				
NEAR YOUR MOUTH			HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS				
HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES			IN THE PAST				
HAVE YOU EVER EXPERIENCED ANY OF THE			HAVE YOU EVER HAD ANY PROLONGED BLEEDING				
FOLLOWING PROBLEMS IN YOUR JAW?			FOLLOWING EXTRACTIONS				
CLICKING			DO YOU WEAR DENTURES OR PARTIALS				
PAIN (JOINT, EAR, SIDE OF FACE)			IF YES, DATE OF PLACEMENT				
DIFFICULTY IN OPENING OR CLOSING			HAVE YOU EVER RECEIVED ORAL HYGIENE				
DIFFICULTY IN CHEWING			INSTRUCTIONS REGARDING THE CARE OF				
DO YOU HAVE FREQUENT HEADACHES			YOUR TEETH AND GUMS				
DO YOU CLENCH OR GRIND YOUR TEETH					20 20 20 20 20 20 20 20 20 20 20 20 20 2		
IF YOU COULD CHANGE <u>ANYTHING</u> ABOUT YOUR SM	IILE, W	VHAT WO	DULD YOU CHANGE?				
AUTHORIZATION AND RELEASE I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION OF MY KNOWLEDGE. THE ABOVE QUESTIONS ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUDENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIATHER RECORDS OF ANY TREATMENT OR EXAMINATION RENDERS MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO PAYORS AND/OR HEALTH PRACTITIONERS. I AUTHORIZE AND	HAVE INCO THORIZ AGNOSI ED TO THIRD	BEEN ORRECT E THE S AND ME OR PARTY	INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DE INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTA DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF A RENDERED ON MY BEHALF OR MY DEPENDENTS. X DATE SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR	ND TH AL BIL	AI MY L FOR		
DOCTOR'S COMMENTS		1		NITTE BELLEVILLE			
CICNIATUDE			NATE		1000		
SIGNATURE			DATE		and and the state of		

PATIENT'S NUMBER