DENTAL HISTORY

FORMER DENTIST:_____ADDRESS,CITY,STATE:_____DATE OF LAST X-RAYS:_____
DATE OF LAST DENTAL VISIT:_____HOW OFTEN DO YOU FLOSS:_____HOW OFTEN DO YOU BRUSH:_____

PLEASE CIRCLE ALL THAT APPLY:

BAD BREATH	LOOSE TEETH/BROKEN FILLINGS	SENSITIVITY TO SWEETS	TOOTH PAIN
BLEEDING GUMS	JAW,HEAD,NECK INJURIES	SENSITIVITY WHEN BITING	LIP OR CHEEK BITING
PAIN AROUND EAR	BLISTERS ON LIPS/GUMS	FREQUENT HEADACHES	SENSITIVITY TO HEAT
FINGERNAIL BITING	JAW DIFFICULTY:CLICKING/PAIN	GRINDING TEETH	SENSITIVITY TO COLD

MEDICAL HISTORY

PHYSICIAN'S NAME:_____ DATE OF LAST VISIT:_____

1. ARE YOU CURRENTLY UNDER MEDICAL TREATMENT?

2. HAVE YOU EVER HAD ANY SERIOUS ILLNESSES OR OPERATIONS?

3.ARE YOU CURRENTLY TAKING ANY MEDICATIONS?
PLEASE LIST ALL MEDICATIONS: _____
_____

4. DO YOU SMOKE? DO YOU USE ALCOHOL?

DO YOU USE COCAINE OR OTHER DRUGS?

5. DO YOU WEAR CONTACT LENSES?

6. HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING: PLEASE CIRCLE WHAT APPLIES:

LOCAL ANESTHETICS (EG NOVOCAINE),

PENICILLIN OR OTHER ANTIBIOTICS,

SULFA DRUGS, IODINE, SEDATIVES,

BARBITURATES (SLEEPING PILLS), ASPRIN,

OTHER(EXPLAIN)_____

(WOMEN ONLY) ARE YOU:
PREGNANT? _____
NURSING? _____
BIRTH CONTROL?_____

PLEASE CIRCLE ALL THE APPLY:

AIDS	CHRONIC FATIGUE SYNDROME	HEART MURMUR	MITRAL VALVE PROLAPSE	
ANEMIA	CIRCULATORY PROBLEMS	HEART PROBLEMS	PACEMAKER	SWELLING OF FEET/ANKLES
ARTHRITIS,RHEUMATIAM	CONGENITAL HEART LESIONS	HEPITITIS TYPE ____	PSYCHIATRIC CARE	SWOLLEN NECK GLANDS
ARTIFICIAL JOINTS	CORTISONE TREATMENTS	HERPES	RADIATION TREATMENT	THYROID PROBLEMS
ASTHMA	COUGH (PERSISTANT/BLOODY)	HIGH BLOOD PRESSURE	RESPIATORY DISEASE	TONSILITIS
BACK PROBLEMS	DIABETES	HIV POSITIVE	RHEUMATIC FEVER	TUBERCULOSIS
BLEEDING ABNORMALLY (WITH SURGERY OR EXTRACTIONS)	EMPHSEMA	JAUNDICE	SCARLET FEVER	TUMOR OR GROWTH ON HEAD/NECK
BLOOD DISEASE	EPILEPSY	LATEX SENSITIVITY	SHORTNESS OF BREATH	ULCER
CANCER	FAINTING/DIZZINESS	KIDNEY DISEASE	SINUS TROUBLE	VENEREAL DISEASE
CHEMICAL DEPENDENCY	GLAUCOMA	LIVER DISEASE	SKIN RASH	OTHER
CHEMOTHERAPY	HEADACHES	LOW BLOOD PRESSURE	STROKE	

ASSIGNMENT

I hereby authorize payment directly to Wollaston Dental Care for all insurance benifits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents.
I authorize the above doctor and/or any provider or supplier in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on al insurance submissions.

Signature of Responsible Party: _____Date: _____