Gordon R. Ediger, DDS | Dental Health History | Parkway Plaza Dental

Today's Date:____________

Patient Name ____ Birthdate: ______________

Dental History

Reason for Today's Visit: ____________________________________ Date of last dental care:________________

Check [X] if you have had problems with any of the following:

[ ]Bad Breath [ ]Grinding Teeth [ ]Bleeding Gums [ ]Clicking/popping jaw

[ ]Loose Teeth [ ] Broken fillings [ ]Periodontal Treatment [ ] Sensitivity to cold

[ ]Other: ____

How often do you floss? ________________________ How often do you brush? __________________________

Medical History

Primary Care Physician: ____

Are you under a physician's care now? [ ] Yes [ ] No If yes, please explain:______________________________

Have you ever been hospitalized or had a major operation? [ ] Yes [ ] No If yes, please explain: _________________

Have you ever had any serious head or neck injury? [ ] Yes [ ] No If yes, please explain:______________________

Do you require Pre-Med antibiotics before dental treatment? [ ] Yes [ ] No

Do you use tobacco? [ ] Yes [ ] No If yes: [ ] Chewing tobacco [ ] Smoke

Do you use controlled substances? [ ] Yes [ ] No

Women: Are you [ ] Pregnant/Trying to get pregnant? [ ] Nursing? [ ] Taking oral contraceptives?

Are you allergic to any of the following?

[ ] Aspirin [ ] Penicillin [ ] Codeine [ ] Sulfa Drugs [ ] Latex/Iodine [ ]Local Anesthetics

[ ]Other: ____

Do you have, or have had, any of the following?

[ ]Anemia	[ ]Cortisone Treatment	[ ]High/Low Blood Pressure
[ ]Arthritis	[ ]Diabetes	[ ]HIV/AIDs
[ ]Artificial Heart Valves	[ ]Epilepsy	[ ]Jaw Pain
[ ]Artificial/Replacement Joints	[ ]Emphysema/Respiratory Disorder	[ ]Kidney Disease
[ ]Asthma	[ ]Fainting/Dizziness	[ ]Liver Disease
[ ]Back Problems	[ ]Gastro-Esophageal Reflux Disease	[ ]Mitral Valve Prolapse
[ ]Blood Disease	[ ]Glaucoma	[ ]Pacemaker
[ ]Cancer	[ ]Headaches	[ ]Previous Biopsies
[ ]Circulatory Problems	[ ]Heart Problems	[ ]Radiation Treatment
[ ]Chemical Dependency	[ ]Heart Murmur	[ ]Rheumatic Fever
[ ]Chemotherapy	[ ]Hemophilia/Abnormal Bleeding	[ ]Sinus Trouble
[ ]Cold Sores	[ ]Hyper/Hypothyroid	[ ]Tuberculosis
[ ]Cough, Persistent	[ ]Hepatitis A/B/C	

List any medications you are currently taking: ____

____

In case of emergency, notify: ______________________________________ Phone #: ______________________________

I authorize the dentist to release any information including diagnosis and records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I have answered the above health/medical form accurately and to the best of my ability. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Patient Signature: ____Date:__________________________