Posh Dental Arts

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Patient name: _____Date: _____
What would you like to do today? _____ Are you in dental discomfort today? _____
Former Dentist _____ Address _____
Dentist's Email _____ Phone _____
Date of last Dental Care _____ Date of last x-rays _____
Check ( ) yes or no if you have had problems with any of the following:

☐ Y ☐N Bad Breath
☐ Y ☐N Food collection between teeth
☐ Y ☐N Periodontal treatment
☐ Y ☐N Sensitivity to sweets
☐ Y ☐N Bleeding gums
☐ Y ☐N Grinding or clenching teeth
☐ Y ☐N Sensitivity to cold
☐ Y ☐N Sensitivity when biting
☐ Y ☐N Clicking or popping jaw
☐ Y ☐N Loose teeth or broken fillings
☐ Y ☐N Sensitivity to hot
☐ Y ☐N Sores or growths in mouth

How often do you brush? _____ Floss? _____
How do you feel about the appearance of your teeth? _____
How you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐ Y ☐N
Other information about your dental health or previous treatment _____

Medical History

Physician's name _____ Phone _____
Date of last visit _____ Have you had any serious illnesses or operation? ☐ Y ☐N
If yes, describe _____
Are you currently under physician care? ☐ Y ☐N if yes, describe _____
Have you ever had a blood transfusion? ☐ Y ☐N if yes, give approximate dates _____
Have you ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva. ☐ Y ☐N
Women: Are you pregnant? ☐ Y ☐N Nursing? ☐ Y ☐N Taking Birth control pills? ☐ Y ☐N
Check ( ) yes or no whether you have had any of the following:

☐ Y ☐N AIDS/HIV Positive
☐ Y ☐N Anaphylaxis
☐ Y ☐N Anemia
☐ Y ☐N Arthritis, Rheumatism
☐ Y ☐N Artificial heart valves
☐ Y ☐N Artificial joints
☐ Y ☐N Asthma
☐ Y ☐N Atopic (allergy prone)
☐ Y ☐N Back problems
☐ Y ☐N Blood disease
☐ Y ☐N Cancer
☐ Y ☐N Chemical dependency
☐ Y ☐N Chemotherapy
☐ Y ☐N Circulatory problems
☐ Y ☐N Cortisone treatments
☐ Y ☐N Cough, persistent
☐ Y ☐N Cough up blood
☐ Y ☐N Diabetes
☐ Y ☐N Epilepsy
☐ Y ☐N Fainting
☐ Y ☐N Food allergies
☐ Y ☐N Glaucoma
☐ Y ☐N Headaches
☐ Y ☐N Heart murmur
☐ Y ☐N Heart problems
Describe _____
☐ Y ☐N Hemophilia/Abnormal bleeding
☐ Y ☐N Herpes
☐ Y ☐N Hepatitis
☐ Y ☐N High blood pressure
☐ Y ☐N Jaw pain
☐ Y ☐N Kidney disease or malfunction
☐ Y ☐N Liver disease
☐ Y ☐N Material allergies (latex, wool, metal, chemicals)
☐ Y ☐N Mitral Valve prolapse
☐ Y ☐N Nervous problems
☐ Y ☐N Pacemaker/Heart surgery
☐ Y ☐N Psychiatric care
☐ Y ☐N Rapid Weight gain or loss
☐ Y ☐N Radiation treatment
☐ Y ☐N Respiratory disease
☐ Y ☐N Rheumatic/Scarlet fever
☐ Y ☐N Shingles
☐ Y ☐N Blood thinner/aspirin
☐ Y ☐N Shortness of breath
☐ Y ☐N Skin rash
☐ Y ☐N Spina Bifida
☐ Y ☐N Stroke
☐ Y ☐N Surgical implant
☐ Y ☐N Swelling of feet or ankles
☐ Y ☐N Thyroid disease or malfunction
☐ Y ☐N Tobacco habit
☐ Y ☐N Tonsillitis
☐ Y ☐N Tuberculosis
☐ Y ☐N Ulcer/Colitis
☐ Y ☐N Venereal disease

Is patient currently taking any medication? If yes, list all: _____
Does patient have drug allergies? If yes, list all: _____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Patient/legal guardian signature _____ Date _____

Dentist _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.