

Dental Health History

	Yes	No	
Have you had regular dental care in the past?	<input type="checkbox"/>	<input type="checkbox"/>	Are your teeth sensitive to: (<i>check all that apply</i>) <input type="checkbox"/> Cold <input type="checkbox"/> Hot <input type="checkbox"/> Sweets <input type="checkbox"/> Biting Pressure <input type="checkbox"/> None
Are you happy with the appearance of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you chew on both sides of your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have unusual or frequent pain in: (<i>check all that apply</i>) <input type="checkbox"/> Teeth <input type="checkbox"/> Jaw Joints <input type="checkbox"/> Ears <input type="checkbox"/> None
Are you pleased with your dental health?	<input type="checkbox"/>	<input type="checkbox"/>	
Do your gums bleed when brushing?	<input type="checkbox"/>	<input type="checkbox"/>	
Is there any unusual swelling in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	
Are you frightened by dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	_____ Date and type of your last x-ray
Have you at any time in your life worn braces?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you or have you ever had periodontal disease?	<input type="checkbox"/>	<input type="checkbox"/>	_____ Doctor who took your last x-ray

Medical Health History: General

Have you been under the care of a medical doctor during the past two years? Yes No

If yes, for what reason:

Are you allergic to or have you ever reacted adversely to any medication or substance?

Yes No

If yes, please list:

Physician's Name:

Phone Number:

Do you use any tobacco products? Yes No

If yes, for how long: _____ And how often: _____

Please list all medications or drugs from the past two years to the present:

Do you or have you had any of the following: (check all that apply)

- | | | | | |
|--|---|---|--|--|
| <input type="checkbox"/> Heart Disease/Attack | <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Kidney Trouble | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis B (serum) |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> A.I.D.S. |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> H.I.V. Positive |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Fever Blisters |
| <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Cold Sores |
| <input type="checkbox"/> Heart Pacemaker | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Epilepsy of Seizures | <input type="checkbox"/> Hepatitis A | |

Medical Health History: Women Only

Do you take oral contraceptives? Yes No

Are you pregnant? Yes No

Are you nursing? Yes No

If yes, what month are you currently in? _____

Reserved Appointments:

We are happy to reserve specific times for you to receive Dr. Benson's care. This time is reserved exclusively for you. Therefore, we appreciate 24 hours notice if you must disappoint. Failure to properly notify us will result in \$25 fee.

Patient Acknowledgement: By my signature, I have read and understand the policies of this office.

Signature

Date

Print Name