

## DENTAL HISTORY

Why are you visiting the Dentist today? \_\_\_\_\_

Are you currently experiencing discomfort? **No Yes**

Have you had a serious problem related to any previous dental visit? \_\_\_\_\_

Do you now have or ever experience any pain/discomfort/ clicking in your jaw joint (TMJ/TMD)? **No Yes**

Your current dental health is: **Excellent Good Fair Poor**

Are you pleased with your smile? **Yes No If No, Why?**

Do your gums ever bleed? **Yes No If Yes, When** \_\_\_\_\_

How many times a day do you brush? \_\_\_\_\_

How often do you floss your teeth? \_\_\_\_\_

Are your toothbrush bristles? **Soft Medium Hard**

When was your last dental visit? \_\_\_\_\_

Previous Dentist & Services provided: \_\_\_\_\_

**Do you have or ever experienced any of the following?**

**Please circle all that applies:**

- |  |                            |
|--|----------------------------|
| Sensitivity to cold/heat/sweets/pressure | Food Impaction in teeth    |
| Unfavorable dental experience            | Unpleasant Taste/Breath    |
| Clenching or Grinding                    | Mouth Breathing            |
| Complications from extraction's          | Periodontal Treatment      |
| Red/White patches/growths on tongue      | Orthodontic Treatment      |
| Swelling or lumps in mouth               | Difficulty opening/closing |
| Sounds/pain around ear when eating       | Injury to head/jaw/neck    |
| Cigarette/cigar/pipe/smokeless tobacco   | Blisters in mouth/lips     |
| Oral Habits/Nail biting/Cheek biting     | Other: _____               |

## ACKNOWLEDGMENT & AUTHORITY

I consent to treatment as necessary or desirable for the patient named above, including but not restricted to drugs, medicine, performance of operations & conduct of laboratory, x-ray, or other studies that may be used by the attending Doctor, staff or qualified designate. I authorize Thomas R. Clark, DDS to release any information to third party payors &/or health practitioners. I authorize & request my insurance company to pay Thomas R. Clark, DDS directly, otherwise payable to me. I understand my insurance carrier may pay less than the total bill for services & unconditionally agree to be responsible for and to pay for any & all charges incurred on my behalf or my dependants. I agree & understand that in the event I do not pay Thomas R. Clark, DDS the balance due, and my account is placed in the hands of a collection agency &/or Attorney for collection proceedings, I will be legally responsible for all Attorney/collection fees, court costs, collection costs, consideration for assignment, litigation expenses, as well as any other incidental expenses incurred by Thomas R. Clark, DDS &/or their assignees. I further understand a 1 1/2 % finance charge/month (18% annually) for any balance over 60 days. I agree to pay Thomas R. Clark, DDS a minimum fee of \$40.00 for any appointment I schedule & fail to arrive for or cancel with less than 24 hours advance notice. The information I have given today is correct to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my personal or medical status. I authorize and provide consent to the dental personnel to contact me regarding my dental appointments, account and/or dental care I need. I authorize the dental personnel to perform any necessary dental services and I may need during diagnosis and treatment with my informed consent. If the patient is a minor I certify I am the legal guardian.

Patient, Parent or Agent (Must be 18 years or older) \_\_\_\_\_ Date \_\_\_\_\_

## MEDICAL CHECKLIST

**Do you have or ever experienced any of the following?  
Please circle all areas that apply.**

|  |  |  |
|--|--|--|
| Allergies                                | Artificial Bones/Joints                  | Artificial Valves                        |
| Arthritis                                | AIDS / HIV +                             | Tuberculosis                             |
| Cancer<br>Location: _____                | Chemotherapy /<br>Radiation Treatment    | Congenital Heart<br>Defects              |
| Diabetes                                 | Difficulty Breathing                     | Asthma                                   |
| Drug / Alcohol<br>Concerns               | Eye /Vision Problems /<br>Contact Lenses | Epilepsy / Seizures                      |
| Fainting Spells                          | Fever Blisters / Herpes                  | Heart Attack                             |
| Heart Murmur                             | Heart surgery /<br>Pacemaker             | Hemophilia / Anemia<br>Abnormal Bleeding |
| Hepatitis /<br>Liver Problems            | High / Low<br>Blood Pressure             | Kidney / Bladder<br>Problems             |
| Latex Allergy                            | Medication Allergy:                      | Mitral Valve Prolapse                    |
| Psychiatric Care /<br>Emotional Concerns | Rheumatic Fever                          | Severe / Frequent<br>Headaches           |
| Sinus Problems                           | Stroke                                   | Thyroid Disease                          |
| Sexually Trans. Disease                  | Ulcers / Colitis                         | Fibromyalgia                             |

## MEDICAL HISTORY

Do you have a Medical Doctor? **Yes No**  
Physician's Name & Phone #: \_\_\_\_\_

Date of Last Visit: \_\_\_\_\_

Last Hospitalization: \_\_\_\_\_

Your current physical health is: **Excellent Good Fair Poor**  
Please Explain: \_\_\_\_\_

Are you taking any prescription or over the counter medications?  
(Please list each one, including Vitamins, Minerals &/or Herbs).  
\_\_\_\_\_

Please list Allergies you have (medications & environmental):  
\_\_\_\_\_

Have you had any adverse experience to Local Anesthesia?  
(Used for numbing) **Yes No**

Have you been advised to take Antibiotic Medication before any  
dental procedures? **Yes No**

**For Women:** Are you pregnant? **Yes No** Week # \_\_\_\_\_  
Are you nursing? **Yes No** Taking Birth Control Pills? **Yes No**

**Please share details of any medical conditions or concerns  
that you now have or experienced in the past:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_