Dental History

How long since you have seen a dentist?______________Date of last complete dental exam:______________________
Name of previous dentist:_________________________Why are you changing dentists?____

____

Approximate date of last full mouth x-rays:__________________________________

Yes/No

☐ ☐ Are you having dental problems now? Explain:____
____
____

☐ ☐ Has your dental care been irregular in the past 5 years?
☐ ☐ Is your present dental health poor?
☐ ☐ Have you had bad dental experiences in the past? Explain:____
____

☐ ☐ Are you apprehensive about dental treatment? Why?____
☐ ☐ Would you like nitrous oxide for dental treatment?
☐ ☐ Have you had nitrous oxide before?
☐ ☐ Have you had any periodontal gum treatment?
☐ ☐ Have gum treatments ever been recommended?
☐ ☐ Are you troubled by bad breath?
☐ ☐ Does food usually wedge between certain teeth? Where?____
☐ ☐ Do your gums bleed, or feel tender, or irritated (Circle) Where?____
☐ ☐ Are your teeth sensitive to hot, cold or sweets? (Circle) Where?____
☐ ☐ Do you have any problems with broken teeth or fillings? (Circle) Where?_____________________________________
☐ ☐ Are you aware of grinding or clenching your teeth?
☐ ☐ Do you have T. M. joint problems?
☐ ☐ Are your jaws or teeth sore when you are awake?
☐ ☐ Do you have headaches, earaches, or neck pains? (Circle)
☐ ☐ Are any teeth sensitive to chewing pressure?
☐ ☐ Do you have any loose, chipped, or shifting teeth? (Circle) Where?_______________________________________
☐ ☐ Do you regularly use dental floss?
☐ ☐ Are you unhappy with the appearance of your teeth? Explain.____
____

Please list any additional comments regarding your dental health you would like us to know about.___________________________
____
____

Medical History

Do you have any current health problems? Explain:____
Are you under a physician's care now? Explain:____
Current physician's name:____
Please check if you have any of the following:

☐ Anemia	☐ Artificial Heart Valves	☐ Artificial Joints	☐ Asthma, Respiratory Problems
☐ Cancer	☐ Chemical Dependency	☐ Chemo/Radiation	☐ Diabetes
☐ Epilepsy/Seizures	☐ Heart Murmur	☐ Heart Problems	☐ Hepatitis
☐ High Blood Pressure	☐ HIV/Aids	☐ Rheumatic Fever	☐ Stroke
☐ Mitral Valve Prolapse	☐ Pacemaker	☐ Venereal Disease	☐ Fainting Spells

Please list any medications you are taking:____(continue on bottom of form)
Are you allergic to (please circle) Penicillin Codeine Latex? List any other allergies_____________________________________
Women: Are you pregnant? If so, due date and name of physician:____
Is there any other medical information that you feel I should know about?_____________________________________
____

I understand there is a fee for cancelled appointments without 24 hours notice. I authorize payment of dental benefits to Dr. Robert Iervolino for professional services rendered by my insurance carrier. I authorize the use of my signature for all insurance submissions. I agree to pay the amount unpaid by my insurance carrier and, if needed, costs of collection by an attorney at 33%.

Patient Signature____ Today's Date__________________________________
Parent (if child)____ Today's Date__________________________________

Thank you and again welcome to our practice.
Robert Iervolino, D. D. S., and Paul Hamilton, D. D. S.