ResourceCare
COMMUNITY HEALTH CENTER

PATIENT'S DENTAL HISTORY

PATIENT'S NAME _____ **DATE OF BIRTH** _____

Reason for this visit. _____

When was your last dental visit?_____ What was done then? _____

How often did you visit the dentist before then? _____

Previous dentist (Name and Location) _____

Have you had a complete series of dental films (X-Rays) taken? When/Where _____

How often do you brush your teeth? _____ How often do you floss your teeth? _____

Is your drinking water fluoridated? _____

QUESTIONS	YES	NO
Do your gums bleed while brushing or flossing?		
Are your teeth sensitive to hot or cold liquids/food?		
Are your teeth sensitive to sweet or sour liquids/ food?		
Do you feel pain to any of your teeth?		
Do you have any sores or lumps in or near your mouth?		
Have you had any head, neck, or jaw injuries?		
Have you ever experienced any of the following problems in your jaw? Answer below.		
Clicking		
Pain (joint, ear, side of face)		
Difficulty in opening or closing jaw		
Difficulty in chewing		

QUESTIONS	YES	NO
Do you have frequent headaches?		
Do you clench or grind your teeth?		
Do you bite your lips or cheeks frequently?		
Have you noticed any loosening of your teeth?		
Does food tend to become caught between your teeth?		
Have you ever had periodontal treatment (gums)?		
Have you ever worn a bite plate or other appliance?		
Have you ever had any prolonged bleeding following extractions in the past?		
Do you wear dentures or partials? If YES, date of placement:		
Have you ever received oral hygiene instructions regarding the care of your teeth and gums?		

If you could change anything about your smile, what would you change? _____

_____

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. 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 insurce carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

X_____ Date _____
Signature of Patient or Parent/Guardian if minor.

Dentist Comments _____

_____

_____ Signature _____ Date _____

OVER

PATIENT'S MEDICAL HISTORY

PATIENT'S NAME _____ **DATE OF BIRTH** _____

Although dental staff primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

QUESTIONS	YES	NO
1. Are you in good health?		
2. Have there been any changes in your general health within the past year?		
3. Date of last physical exam:		
4. Physician's Name: _____ Address: _____ Phone #: _____		
5. Are you now under the care of a physician?		
6. Have you ever been hospitalized for any surgical operation or serious illness? If YES, Please Explain:		
7. Have you had any abnormal bleeding?		
8. Do you bruise easily?		

QUESTIONS	YES	NO
9. Have you ever required a blood transfusion?		
10. Have you had recent weight loss?		
11. Have you ever taken Fen-phen/Redux?		
12. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications?		
13. Have you ever taken Viagra, Revatio, Cialis or Lavitra in the last 24 hours?		
14. Do you use tobacco?		
15. Do you or have you used controlled substances?		
16. Are you wearing contact lenses?		
17. Do you have a persistent cough or throat clearing not associated with a known illness? (Lasting more than three weeks)		
WOMEN ONLY: 1. Are you pregnant or think that you may be pregnant?		
2. Are you nursing?		
3. Are you taking birth control pills?		

Are you allergic to, or have you had reactions to:	YES	NO
Local anesthetic like Novocain		
Penicillin or other antibiotics		
Sulfa drugs		
Barbiturates, sedatives or sleeping pills		
Aspirin		
Iodine		
Any metals (i.e. Nickel, Mercury, ect.)		
Latex / Rubber		
Other: Please List		
Do you have, or have you ever had the following:	**YES**	**NO**
Rheumatic heart disease or rheumatic fever		
Scarlet fever		
Heart defect or heart murmur		
Heart trouble, heart attack, or angina		
Chest pain		
Shortness of breath		
Pacemaker		
Heart surgery		
High/Low blood pressure		
Congenital heart problem		
Swelling of feet, ankles, hands		
Hepatitis, jaundice or liver disease		
Stroke		
Sinus Trouble		
Lung or breathing problems		
Asthma or hay fever		
Eating disorders		

Hives or skin rash		
Fainting or dizzy spells		
Diabetes		
AIDS or HIV infection		
Thyroid problems		
Allergies		
Arthritis or rheumatism		
Joint replacement or implant		
Stomach ulcer		
Kidney trouble		
Tuberculosis		
Persistent cough		
Cough that produces blood		
Chemotherapy (Cancer, Leukemia)		
Sexually Transmitted disease		
Epilepsy or seizures		
Anemia		
Glaucoma		
Nervousness		
Tonsillitis		
Tumors		
Mental health care		
Back problems		
Chemical dependency		
Mitral valve prolapsed		
Cortisone treatment		
Cold sores/fever blisters		
Hypoglycemia		

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MEDICATIONS TAKEN REGULARLY

Name of Medication	Date Started	Dosage/Schedule	Date Stopped	Additional Comments

Allergies to medication and reaction: _____

_____

_____

Environmental and Occupational

What kind of work do you do? _____

If Unemployed, Do you think your health problems are related to your home or other location? ☐ Yes ☐ No

If Employed , Do you think your health problems are related to your home or other location? ☐ Yes ☐ No

Are your symptoms better or worse when you are at home or at work? ☐ Yes ☐ No

Are you now or have you previously been exposed to pesticides, solvents, or other chemicals, dusts, fumes, radiation, or loud noise? ☐ Yes ☐ No

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GENERAL DENTISTRY INFORMED CONSENT

Dentist: _____ Patient: _____

1) WORK TO BE DONE: I understand that I am receiving an exam with any necessary x-rays.

2) DRUGS AND MEDICATION: I understand that I may need antibiotics, analgesics, and other medications based on my diagnosis and that these medications can cause allergic reactions resulting in redness and swelling of tissue, pain, itching, vomiting, and/or anaphylalic shock. I understand that it is my responsibility to disclose any known allergies to medications.

3) CHANGES IN TREATMENT PLAN: I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during previous examination. For example, root canal therapy following routine restorative procedures. I give my permission to my dentist to make any/all changes and additions as necessary. In case that treatment changes, the dentist will alert you and have you sign a separate consent form before proceeding.

4) REMOVAL OF TEETH: In case of extractions being the treatment on teeth that can be saved by alternative methods, I understand that the dentist will explain to me the alternatives. (root canal therapy, crowns, periodontal surgery, etc.) and allow me to decide which procedure to proceed with. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (that can last for an indefinite period of time) or a fractured jaw. I understand I may need further treatment by a specialist if complications arise during or following treatment, the cost for which is my responsibility.

5) CROWNS, BRIDGES, AND CAPS: I understand if I may need crowns, bridges, or caps that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, and color) will be before cementation. It is also my responsibility to return for permanent cementation within 21 day from tooth preparation. Excessive delays may allow for tooth movement. This may necessitate a remake of the crown, bridge, or cap. I understand that there will be additional charges for remakes due to my delaying permanent teeth cementation.

6) ENDODONTIC TREATMENT (ROOT CANAL): I realize that if I may need a root canal, there is no guarantee that root canal therapy will save my tooth, that complications can occur from the treatment, and that occasionally root canal filling material may extend through the tooth, which does not necessarily affect the success of the treatment. I understand that endodontic files are very fine instruments and stresses from their manufacturer can cause them to separate during use. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicotectomy). I understand I may need further treatment by an endodontic specialist if complications arise during or following treatment, the cost for which is my responsibility. I understand that the tooth may be lost in spite of all efforts to save it.

7) PERIODONTAL LOSS (tissue and bone): I understand that if I am diagnosed with periodontal disease that I have a serious condition, causing gum and bone inflammation or loss that it can to the loss of my teeth. Alternative treatment plans will be explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedure may have a future adverse effect on my periodontal condition.

8) FILLINGS: I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more extensive filling than originally diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect on a newly placed filling.

By signing this consent form, you acknowledge that you have read, agree to, and understand the protocols, procedures, and associated risks. Any necessary treatment will have its own separate consent form and will be signed on the date of service before the procedure is performed. I understand that dentistry is not an exact science and that therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment, which I have requested and as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or un-diagnosable circumstances that may exist during the course of treatment. I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of the dental fees. I agree to pay any attorney's fees, or court costs, that be incurred to satisfy this obligation.

_____ _____

Signature of Patient/Guardian Date

_____ _____

Signature of Dentist Date