IMPRESSIONS DENTAL CG

Dental and Medical History Information

Dental History

Reason for today's visit? ☐ **Recare/Cleaning** ☐ **Dental Concern:** _____
Former Dentist _____ **City/ State** _____
Date of Last Visit _____ **Date of last dental x-rays**_____
How often do you floss? _____ **How often do you brush?** _____

Please check all that apply:

- ☐ Bad Breath
- ☐ Bleeding gums
- ☐ Blisters on lips or mouth
- ☐ Burning sensation on tongue
- ☐ Chew on one side of mouth
- ☐ Cigarette/pipe/cigar smoking
- ☐ Clicking or popping jaw
- ☐ Dry mouth
- ☐ Fingernail biting
- ☐ Food collection between teeth
- ☐ Foreign objects
- ☐ Grinding teeth
- ☐ Gums swollen or tender
- ☐ Jaw pain
- ☐ Jaw tiredness
- ☐ Lip or cheek biting
- ☐ Loose teeth/broken fillings
- ☐ Mouth breathing
- ☐ Mouth pain, brushing
- ☐ Orthodontic treatment
- ☐ Pain around ear
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to heat
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores/growths in mouth

Health History

Current Physician's Name _____ **Date of Last Visit** _____
Recent Surgery's _____ **Date of Surgery**_____

Do you wear Contact Lenses? ☐ **No** ☐ **Yes**

Have you ever taken any medications containing bisphosphonates? This includes brands such as Fosamax, Actonel, Didronel, Boniva, Aredia, and Zometa ? ☐ **No** ☐ **Yes**

Are you currently on a blood thinners or aspirin? ☐ **No** ☐ **Yes - I am taking** _____

Female Patients - Are you taking birth control pills? ☐ **No** ☐ **Yes** **Are you pregnant?** ☐ **No** ☐ **Yes - Due Date**_____
Are you currently nursing? ☐ **No** ☐ **Yes**

Please check all that apply:

- ☐ AIDS/HIV
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Bleeding abnormally, with extractions or surgery
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Lesions
- ☐ Cortisone Treatments
- ☐ Cough, persistent/bloody
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting/ Dizziness
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hepatitis Type _____
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Skin Rash
- ☐ Special Diet
- ☐ Stroke
- ☐ Swollen Feet/Ankles
- ☐ Swollen Neck Glands
- ☐ Thyroid Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumor or growth on head or neck
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Weight Loss/Gain

Medications

List any medications you are currently taking and the correlating diagnosis:_____

_____

Allergies

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Latex
- ☐ Metals
- ☐ Penicillin
- ☐ Sulfa
- ☐ Tetracycline
- ☐ Other _____

I authorize and give consent to perform dental services agreed between Impressions Dental CG and its associates and patient and/or parent or guardian to be necessary or advisable including the use of anesthesia and other medication as indicated. I certify to the accuracy of the above statements regarding my medical and dental history. Payment for all treatment and services rendered are my responsibility.

_____ _____ _____
Signature of patient, parent, guardian or personal representative **Printed name of patient, parent, guardian, or personal representative** **Date**