Dental History

Reason For Today's Visit _____ **Date of Last Dental Care?** _____

Former Dentist _____ **Date of Last Dental X-Rays?** _____

Check (✔) If You Have or Have Had Problems With Any Of The Following:

☐ Bad Breath	☐Food Collection Between Teeth	☐Periodontal Treatment	☐ Sensitivity To Sweets
☐ Bleeding Gums	☐ Grinding Teeth	☐ Sensitivity To Cold	☐ Sensitivity When Biting
☐ Clicking or Popping Jaw	☐ Loose Teeth/Broken Fillings	☐ Sensitivity To Hot	☐ Sores/Growths In Mouth

Medical History

Physician's Name _____ **Date of Last Visit** _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of Phertermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, describe _____

Women only - Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking Birth Control Pills? ☐ Yes ☐ No

Check (✔) If You Have or Have Had Any Of The Following:

☐AIDS/HIV Positive	☐Cortisone Treatments	☐Hepatitis A_____ B_____ C_____	☐Scarlet Fever
☐Anaphylaxis	☐Cough, Persistent	☐Hernia Repair	☐Shingles
☐Anemia	☐Cough Up Blood	☐High Blood Pressure	☐Shortness of Breath
☐Arthritis, Rheumatism	☐Dentures/Partials	☐Jaw Pain	☐Skin Rash
☐Artificial Heart Valves	When?_____	☐Kidney Disease/Malfunction	☐Stroke
☐Artificial Joints	☐Diabetes	☐Liver Disease	☐Swelling of Feet/Ankles
☐Asthma	☐Epilepsy	☐Material Allergies	☐Thyroid Problems
☐Back Problems	☐Fainting	(Latex, Wool, Metal, Chemicals)	☐Tobacco Habit
☐Blood Disease	☐Glaucoma	☐Mitral Valve Prolapse	☐Tonsillitis-Removed? _____
☐Cancer	☐Headaches	☐Osteoporosis Therapy	☐Tuberculosis
☐Chemical Dependency	☐Heart Murmur	☐Pacemaker/Heart Surgery	☐Ulcer/Colitis
☐Chemotherapy	☐Heart Problems	☐Radiation Therapy	☐Venereal Disease
☐Circulatory Problems	Describe_____	☐Respiratory Disease	

MEDICATIONS

List any medications you are currently taking and the correlating Diagnosis:

_____

_____

_____

Pharmacy Name _____

Phone # ( ) _____

ALLERGIES

☐ Aspirin	☐ Local Anesthetic
☐ Tylenol	☐ Penicillin
☐ Codeine	☐ Sulfa
☐ Metal_____	☐ Other_____
☐ Latex	_____

AUTHORIZE AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a sudden change in health. I certify that I, and/or my dependents, have insurance coverage with _____ and assign Dr. Tara Scallion, directly, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Dr. Tara Scallion may use my healthcare information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits, or the benefits payable for related services. This consent will end when the current treatment plan is completed, or one year from the date signed below.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please Print Name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient