John H. Bailey D.D.S., F.A.C.P., LLC

MEDICAL / DENTAL HISTORY :

Patient Name _____ **Date** ___/___/___
Last First MI

Primary reason for this dental appointment: ☐ **Examination** ☐ **Emergency** ☐ **Consultation**

Medical Doctor's Name _____ Address _____ Phone Number (____)_____

Are you under a Doctor's care now? ☐ YES ☐ NO If Yes, please explain _____
Have you ever been hospitalized or had a major Operation? ☐ YES ☐ NO If Yes, please explain _____
Have you ever had a serious head or neck injury? ☐ YES ☐ NO If Yes, please explain _____
Are you taking any medications, pills, or drugs? ☐ YES ☐ NO If Yes, please explain _____
Do you take or have you taken Phen-Fen or Redux? ☐ YES ☐ NO _____
Are you on a special diet? ☐ YES ☐ NO _____
Do you use tobacco? ☐ YES ☐ NO
Do you use controlled substances? ☐ YES ☐ NO

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codiene ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anethetics
☐ Other If yes, please explain: _____

Women: Are you ☐ Pregnant / Trying to get pregnant? ☐ Nursing? ☐ Taking oral conceptives?

Current Medications

Please provide a complete description of any medication you are presently taking.

_____
_____
_____
_____
_____
_____
_____
_____

Do you have any of the following:

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Irregular Heart Beat	☐ Scarlet Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Kidney Problems	☐ Shingles
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Leukemia	☐ Sickle Cell Disease
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Liver Disease	☐ Sinus Trouble
☐ Angina	☐ Cortisone Medications	☐ Heart Attack / Failure	☐ Low Blood Pressure	☐ Spins Bifida
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Lung Disease	☐ Stomach / Intestinal Disease
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pace Maker	☐ Mitral Valve Prolapse	☐ Stroke
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble / Disease	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Psychiatric Care	☐ Tonsillitis
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Radiation Treatments	☐ Tuberculosis
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Renal Dialysis	☐ Ulcers
☐ Cancer	☐ Frequent Cough	☐ Hives or Rash	☐ Rheumatic Fever	☐ Venereal Disease
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hypoglycemia	☐ Rheumatism	☐ Yellow Jaundice

Have you ever had any serious illness not circled above? ☐ YES ☐ NO
Describe in detail (Back of form)

DESCRIPTION OF SERIOUS ILLNESS :

Please provide a complete description to include nature of illness, when occurred, and treating physician. Please proved contact numbers and/or address of all physicians or hospitals .

_____

_____

_____

_____

_____

_____

_____

_____

DENTAL HISTORY :

Date of last dental examination _____/_____/_____

Who referred you to our office? _____

Name of previous dentist (optional) _____

Do you feel nervous about having dental treatment? ☐ YES ☐ NO

Do you have a specific dental problem? Describe _____ ☐ YES ☐ NO

Have you been satisfied with your previous dental care? ☐ YES ☐ NO

If No, explain _____

Have you had any serious trouble associated with any previous dental treatment? ☐ YES ☐ NO

If No, explain _____

Are your teeth sensitive to : Hot: ☐ YES ☐ NO Cold: ☐ YES ☐ NO Sweets: ☐ YES ☐ NO

How often do you brush your teeth? _____

Do you use Dental Floss? ☐ YES ☐ NO

Do you want to keep your remaining teeth? ☐ YES ☐ NO

Do you like your smile? Why? _____ ☐ YES ☐ NO

Do you think you have active decay or gum disease? ☐ YES ☐ NO

Do your gums ever bleed? Discuss _____ ☐ YES ☐ NO

Have you been treated for: ☐ Gingivitis ☐ Periodontosis ☐ Trench Mouth ☐ Pyorrhea ☐ YES ☐ NO

Have you had any injuries to your mouth or jaws? ☐ YES ☐ NO

If Yes, explain _____

Do you ever brux or grind your teeth? How often? _____ When?_____ ☐ YES ☐ NO

Have you ever had orthodontic treatment (tooth straightening)? ☐ YES ☐ NO

Do you ever have ☐ clicking, ☐ popping, or ☐ discomfort in the jaw joints (TMJ)? ☐ YES ☐ NO

Discuss _____

I hereby grant my permission to Dr. John H. Bailey to administer anesthetic and other drugs or pharmaceuticals; to remove any tissue and/or structure; to use such operative and technical procedures necessary to complete a diagnosis and/or recommended treatment; and to accept the sequence in which the diagnosis and treatment plan will be accomplished. I also grant my permission to acquire and use all or any part of my records, photographs, video tapes, films which may be required for examination, diagnosis, treatment and/or scientific presentation.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health.
It is my responsibility to inform the dental office of any changes in my health status.

_____ **Date** _____/_____/_____

Patient Signature (Legal Guardian or Parent if Minor)