



Are you currently taking any medications?      Yes      No

If yes, please list all medications: \_\_\_\_\_

Do you use tobacco?      Yes      No

Do you have any other conditions not listed above that we should be aware of?    Yes    or    No

Please explain:

\_\_\_\_\_

Women only: Are you pregnant?      Yes      No

Are you taking birth control pills?      Yes      No

Are you nursing?      Yes      No

Please indicate if you have experienced any of the following:

- |                                                |                                                |                                                   |
|------------------------------------------------|------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Pre-med Amoxicillin   | <input type="checkbox"/> Epilepsy              | <input type="checkbox"/> Nervous disorders        |
| <input type="checkbox"/> Pre-med Clindamycin   | <input type="checkbox"/> Excessive bleeding    | <input type="checkbox"/> Pacemaker                |
| <input type="checkbox"/> Allergy to medication | <input type="checkbox"/> Fainting              | <input type="checkbox"/> Peanut allergy           |
| <input type="checkbox"/> Seasonal allergies    | <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Radiation treatment      |
| <input type="checkbox"/> Latex allergy         | <input type="checkbox"/> Head injuries         | <input type="checkbox"/> Red dye allergy          |
| <input type="checkbox"/> Anemia                | <input type="checkbox"/> Heart disease         | <input type="checkbox"/> Respiratory problems     |
| <input type="checkbox"/> Arthritis             | <input type="checkbox"/> Heart murmur          | <input type="checkbox"/> Rheumatic fever          |
| <input type="checkbox"/> Artificial Joints     | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Rheumatism               |
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> High blood pressure   | <input type="checkbox"/> Sensory issues           |
| <input type="checkbox"/> Blood disease         | <input type="checkbox"/> HIV                   | <input type="checkbox"/> Sinus problems           |
| <input type="checkbox"/> Cancer                | <input type="checkbox"/> Jaundice              | <input type="checkbox"/> Speech/ hearing problems |
| <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Kidney disease        | <input type="checkbox"/> Stomach problems         |
| <input type="checkbox"/> Dizziness             | <input type="checkbox"/> Liver disease         | <input type="checkbox"/> Stroke                   |
| <input type="checkbox"/> Down's Syndrome       | <input type="checkbox"/> Mental disorders      | <input type="checkbox"/> Tuberculosis             |
| <input type="checkbox"/> Ear tubes             | <input type="checkbox"/> Mitral valve prolapse |                                                   |

What is the reason for your dental visit?

\_\_\_\_\_

When was your last dental visit?

\_\_\_\_\_

What was done on your last dental visit?

\_\_\_\_\_

Previous Dentist's name, address, & phone number:

\_\_\_\_\_

How often do you brush?

---

How often do you floss?

---

Please circle Y or N for the following:

Do your gums bleed when you brush or floss? Y N

Have you experienced any sensitivity to cold or hot? Y N

Are you currently experiencing any pain with your teeth? Y N

Do you grind your teeth? Y N

Do you experience discomfort in your jaws? (TMJ or TMD) Y N

Have you ever experienced any complications after dental treatment? Y N

If you could change anything about your mouth, teeth or smile, what would it be?

#### Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize Dr. Schwendiman to release any information including the diagnosis and records of treatment or examination for myself and my dependents to third party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to Dr. Schwendiman or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependants (if any).

Signature of patient/parent/guardian:

\_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_