

Shary A. Henderson, D.D.S.

Confidential Medical/Dental Information

Name _____ Birthdate _____

Occupation _____ Interests _____

Physician _____ Last physical _____

Please circle if you have had a history of any of the following

heart condition	convulsions/seizures	mumps/measles/
heart murmur	epilepsy	chicken pox
rheumatic fever	fainting	emotional issues
anemia	hepatitis	fibromyalgia
high blood pressure	liver disease	arthritis
bleeding problems	cancer/tumor	osteoporosis
stroke	radiation	physical handicap
kidney disease	ulcers	venereal disease
diabetes	respiratory/asthma	hiv/aids
hypoglycemia	hay fever/hives/allergy	latex allergy
thyroid problems	memory loss/alzheimer	other: _____

Please explain any positive responses _____

Please list hospitalizations for illness, accident or surgery _____

Please list any allergy to Penicillin/Codeine or other Meds _____

Are you pregnant or breast feeding? _____ Do you eat a balanced diet? _____

Do you exercise regularly? _____ Do you smoke/dip tobacco? _____ How long? _____

How many alcohol drinks in a week? _____

On a Scale of 1-10 (10 being the best), how would you rate your overall health? _____

Please List All Medications, Over-the-Counter Drugs, Vitamins and Herbs you are currently taking:

- | | | |
|----------|-----------|-----------|
| 1. _____ | 6. _____ | 11. _____ |
| 2. _____ | 7. _____ | 12. _____ |
| 3. _____ | 8. _____ | 13. _____ |
| 4. _____ | 9. _____ | 14. _____ |
| 5. _____ | 10. _____ | 15. _____ |

DENTAL INFORMATION

How did you hear about our office? _____

When was your last dental visit and what was it for? _____

Are you having pain or sensitivity? _____

Please circle any of the following which you have experienced:

Filling	Cleaning	Bridge	Crown/cap
Braces	Gum treatment	Root canal	Extraction
Implant	Partial	Denture	Deep cleaning

Describe any injuries to your face or teeth: _____

Are you comfortable with the function of your mouth and chewing system? _____

Do you have any places which catch or trap food often? _____

Are you missing any permanent teeth (other than wisdom teeth)? _____

Do your gums ever bleed when you floss or brush? _____

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

What other methods do you use to clean your mouth and teeth. _____

Are you aware of clenching/grinding of your teeth during the day or night? _____

Do you have headaches? _____ Do you have pain in your jaw? _____

Are you happy with the appearance of your teeth and smile? _____

On a scale of 1-10 (10 being the best), how would you rate your dental health?

1 2 3 4 5 6 7 8 9 10

I hereby authorize the doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or staff. I agree to pay for all services rendered by this office.

Signature

Date