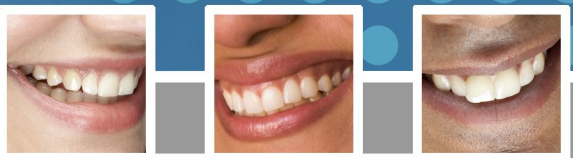
Dental Care, P.C.
415 E. Coolbaugh
Red Oak IA 51566

(712)623-3383



Health History

Patient Name:* _____ (Last) * _____ (First) _____ (MI) _____ (Preferred Name)

Do you have (or have you ever had) any of the following?

Has there been any change in your general health within the past year?

* ◯ Yes ◯ No

Have you had an illness or operations?

* ◯ Yes ◯ No

Any recent unexplained gain or loss of weight?

* ◯ Yes ◯ No

Have you been hospitalized within the last two years?

* ◯ Yes ◯ No

Have you ever been told by a dentist or physician to pre-medicate prior to dental procedures?

* ◯ Yes ◯ No

If yes to any of the above questions, please explain.

Please list the name, number and address of your physician.

If you use a specific pharmacy please list name, address and phone number below.

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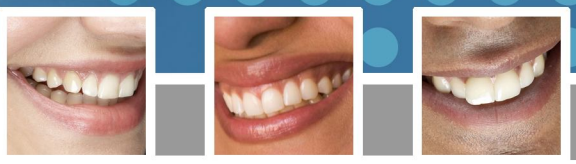

Please check if you had or have any of the following and explain on the following page:

- ☐ Allergies
- ☐ Angina
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Cancer
- ☐ Diabetes
- ☐ Emphysema
- ☐ Excessive Bleeding
- ☐ Fibromyalgia
- ☐ Growth/Tumor
- ☐ High or Low Blood Pressure
- ☐ Heart Attack/Disease
- ☐ Heart Murmur
- ☐ Jaundice
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pain in Jaw Joint
- ☐ Respiratory Problems
- ☐ Sexually-Transmitted Disease/AIDS/HIV+
- ☐ Steroid Therapy
- ☐ Stroke
- ☐ Take Blood Thinners
- ☐ Take Premedication
- ☐ Tuberculosis
- ☐ Anemia
- ☐ Arthritis Osteo or Rheumatoid
- ☐ Artificial Joint
- ☐ Bleeding Disorder
- ☐ Chemotherapy/Radiation
- ☐ Drug/Substance Addiction
- ☐ Epilepsy/Seizures
- ☐ Fainting/Dizzy
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injury
- ☐ Heart Failure/Surgery
- ☐ Hepatitis A, B, C or D
- ☐ Kidney Disease
- ☐ Mental Disorder
- ☐ Pacemaker
- ☐ Physical/Mental Disability
- ☐ Rheumatic or Scarlet Fever
- ☐ Sinus Trouble
- ☐ Stomach Problems/Acid Reflux
- ☐ Take Bisphosphonates
- ☐ Taking Medications
- ☐ Thyroid Disease
- ☐ Ulcer

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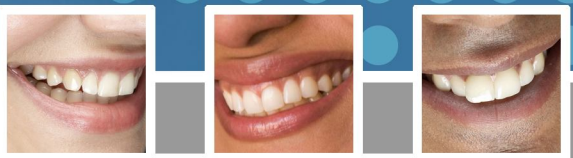

Please explain any diseases/illnesses you checked on the previous page.

Are you pregnant or nursing?

* ◯ Yes ◯ No

Do you use any tobacco products?

* ◯ Yes ◯ No

If yes, what tobacco product(s) do you use and how often?

Please list any allergies you have.

Please list any medications you are currently taking, its dosage and frequency below.

Do you have any other disease, condition, or take any other medication not listed above?

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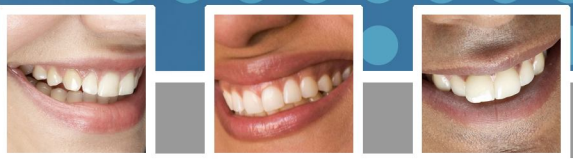

Dental History

What is your reason for visiting today?

*

Date of last dental visit.

What was done at last visit (cleaning, filling, extraction)?

Date of last dental x-rays.

Former dentist, address and phone number.

Please call your former dentist to forward your records. If you prefer we call, please contact our office prior to your appointment.

Check if you have had problems with any of the following?

- ☐ Bad breath
- ☐ Clicking or popping jaw
- ☐ Grinding teeth
- ☐ Broken fillings
- ☐ Sensitivity to cold
- ☐ Sensitivity to sweets
- ☐ Sores/lumps in the mouth
- ☐ Injured your face, jaws or teeth
- ☐ Fear preventing you from seeking dental care
- ☐ Bleeding gums
- ☐ Food collection between teeth
- ☐ Loose teeth
- ☐ Perio treatment/deep cleaning
- ☐ Sensitivity to hot
- ☐ Sensitivity to biting
- ☐ Trouble brushing teeth
- ☐ Pain in the mouth, neck, eyes, face, or throat

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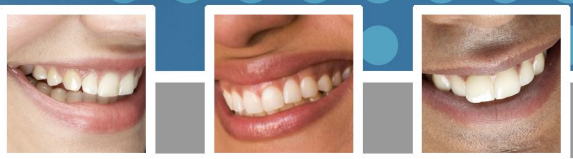

Please list below any metals or dental materials you are allergic to.

Please check the types of dental treatment you have experienced:

- ☐ Orthodontics (braces)
- ☐ Dentures
- ☐ Veneers
- ☐ Implants
- ☐ Oral surgery
- ☐ Periodontal (gum) disease
- ☐ Root canal treatment
- ☐ TMJ treatment
- ☐ Crowns
- ☐ Bridges
- ☐ Bleaching
- ☐ Fillings

How often do you floss?

How often do your brush?

Is there anything you would like to change about your smile?

What did you like most about any dentist you have seen?

What did you least like about any dentist you have seen?

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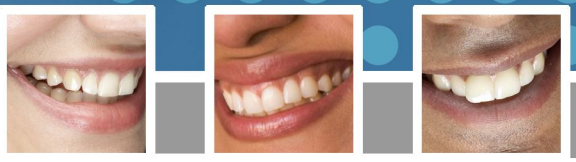

Consent

I give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by the supervised staff for diagnostic purpose or dental treatment.

I understand and acknowledge that I am financially responsible for the services provided for myself or the above named, regardless of insurance coverage.

As a condition of your treatment by this office, financial arrangements must be made in advance. All emergency dental services, or services performed without prior financial arrangements, must be paid at the time of service.

I have read the above conditions of treatment and payment and agree to their content.

Response Date: _____