AD)A.	American Dental Assoc www.ada.org	iation,	Maine Asa:	Contrilion	Premedication:	Allergias:	Ancathasia:	Date;	
				<u>OFERST PARTERS</u>					
Name:				Home Pho	ne: ()	Bu	siness Phone: ()	
Address:	LAST	FIRST	MIDDLE	City			State:	Zip Code:	
Occupatio	P.O. BDX or Mailing Address			Height:	Weight:	Da	te of Birth:	Sex: M 🗆	FO
<u>SS#:</u>	·····	Eme	rgency Contact:	· · · · · · · · · · · · · · · · · · ·	Relations	ship:	Pho	one: ()	
If you are o	completing this form	n for another	person, what is you	ir relationship to that p	person?				
						NAME	B	ELATIONSHIP	

For the following questions, please (X) whichever applies, your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

DENTAL INFORMATION

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	Yes	s No	Don't Know
Do your gums bleed when you brush?		Ο	
Have you ever had orthodontic (braces) treatment?			
Are your teeth sensitive to cold, hot, sweets or pressure?			C
Do you have earaches or neck pains?			Ū
Have you had any periodontal (gum) treatments?			·□
Do you wear removable dental appliances?			
Have you had a serious/difficult problem associated			
with any previous dental treatment?			D
If yes, explain:			

How would you describe your current dental problem?

Date of your last dental exam:

Date of last dental x-rays:

What was done at that time?

How do you feel about the appearance of your teeth?

	· M	न्त्र	CAL IS	IFORMATION			
	Yes N		Don't Know		Yes	s No	Don't Know
If you answer yes to any of the 3 items below, please stop and return this form to the receptionist.				Are you taking or have you recently taken any medicine(s) including non-prescription medicine? If yes, what medicine(s) are you taking?		D	٥
Have you had any of the following diseases or problems2				Prescribed:			
Active Tuberculosis Persistent cough greater than a 3 week duration Cough that produces blood	0:C 0:C	j C	1	Over the counter:			
Are you in good health?		з с	C	Vitamins, natural or herbal preparations and/or diet suppleme	ents:		
Has there been any change in your general health within the past year?) C	נ				
Are you now under the care of a physician? If yes, what is/are the condition(s) being treated?) C] 	Are you taking, or have you taken, any diet drugs such Pondimin (fenfluramine), Redux (dexphenfluramine) or phen-fen (fenfluramine-phentermine combination)?			D
Date of last physical examination:				Do you drink alcoholic beverages?	۵		
		_		If yes, how much alcohol did you drink in the last 24 hours?			
Physician:				In the past week?			
ADDRESS CITWSTATE	ZIP			Are you alcohol and/or drug dependent? If yes, have you received treatment? (circle one) Yes / No	۵	۵	۵
NAME PHONE				Do you use drugs or other substances for			
ACCIRESS CITY/STATE	ZIP		-	recreational purposes? If yes, please list:	ĽI.		D
Have you had any serious illness, operation,				Frequency of use (daily, weekly, etc.):			
or been hospitalized in the past 5 years? If yes, what was the illness or problem?	0 0	ם כ]	Number of years of recreational drug use:			
				Do you use tobacco (smoking, snuff, chew)? If yes, how interested are you in stopping? (circle one) Very / Somewhat / Not interested	٥	٥	C
				Do you wear contact lenses?	O	Ω	D

PLEASE COMPLETE BOTH SIDES

Cancer/Chemotherapy/Radiation Treatment Image: Chemotherapy/Radiation Treat		0	0
Aspirin Image: Construction of the antibiotics Image: Construction of the constructio			0
Penicilin or other antibiotics If yes, when was this operation done? Barbiturates, so delives, or sleeping pills If you answered yes to the above question, have you had Stafe drugs If you answered yes to the above question, have you had Codeline or other narcotics If you answered yes to the above question, have you had Codeline or other narcotics If you answered yes to the above question, have you had Codeline or other narcotics If you answered yes to the above question, have you had Codeline or other narcotics If you answered yes to the above question, have you had Codeline or other narcotics If you answered yes to the above question, have you had Codeline or other narcotics If you answered yes to the above question, have you had Codeline or other narcotics If you answered yes to the above question, have you had Animals If you answered yes to the above question, have you had Animals If you answered yes to the above question or dentist: Please (X) If you answered yes to the above question or dentist: Please (X) a response to indicate if you have or have not had any of the following diseases or problems. Don't Abormal bleeding If yes, hone Hemophilia AlDS or h't infection If yes, hone Hemophilia <t< td=""><td></td><td></td><td>0</td></t<>			0
Barbiturates, sedatives, or sleeping pills I If you answered yes to the above question, have you had any complications or difficulties with your prosthetic joint? Codeline or other narcotics I I If you answered yes to the above question, have you had any complications or difficulties with your prosthetic joint? Latex I I III you answered yes to the above question, have you had any complications or difficulties with your prosthetic joint? Latex III yee, what at bitotic cand dose? III yee, what at bitotic cand dose? Cher (specify) III yee, what at bitotic cand dose? III yee, what at bitotic cand dose? Cher (specify) III yee, what at bitotic cand dose? Name of physician or dentist: Metals (specify) III yee, what at bitotic cand dose? Name of physician or dentist: Metals (specify) III yee, what at bitotic cand dose? Narsing? To yee response to indicate if you have or have not had any of the following diseases or problems. WOMENVONV Abnormal bleeding IIII Yee, indicate type of infection: IIII Photone Abnormal bleeding IIII Yee, indicate type of infection: IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII			
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Latex Lodine Lod			
locine			
Hay fever/seasonal			
Animais Image: Constraint of the problems Food (specify) Image: Constraint of the problems Cher (specify) Image: Constraint of the problems Metals (specify) Image: Constraint of the problems Metals (specify) Image: Constraint of the problems Metals (specify) Image: Constraint of the problems Image: Constraint of the problems Image: Constraint of the problems Image: Constraint of the problems Image: Constraint of the problems Image: Constraint of the problems Image: Constraint of the problems Image: Constraint of the problems Image: Constraint of the problems Image: Constraint of the problems Image: Constraint of the problems Anthritis Image: Constraint of the problems Image: Constraint of the problems Anthritis Image: Constraint of the problems Image: Constraint of the problems Anterioscierosis High blood pressure Persistent swollen glands in neck Anterioscierosis High blood pressure Persistent swollen glands in neck Congenital heart defects Mitrai valve prolapse Emphysicant neck Congenital heart defects Mitrai valve prolapse Emphysicant neck Congenital heart defects			
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Other (specify) Image: Specify type of reaction. Phone: To yes responses, specify type of reaction. Phone: Image: Specify type of reaction. WOMENCONNY Are you or could you be pregnant? Nursing? Taking bith control pills or hormonal replacement? Please (X) a response to indicate if you have or have not had any of the following diseases or problems. Don't Abnormal bleeding Image: Specify type of indicate if you have or have not had any of the following diseases or problems. Don't Abnormal bleeding Image: Specify type of indicate if you have or have not had any of the following disease or problems. Hemophilia Albor risk (A response to indicate if you have or have not had any of the following diseases or problems. Don't Abnormal bleeding Image: Specify type of indicate if you have or have not had any of the following disease or problems. Hemophilia Albor risk (A response to indicate if you have or have not had any of the following diseases or problems. Hemophilia Albor risk (M or risk (M	0 0 0		
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To yes responses, specify type of reaction. WOMENONIX Are you or could you be pregnant? Are you or could you be pregnant? Nursing? Taking birth control pills or hormonal replacement? Please (X) a response to indicate if you have or have not had any of the following diseases or problems. Don't Abnormal bleeding Image: Don't Anemia Image: Don't Arenia Image: Don't String Head thitis Asthma Image: Don't Arteriosclerosis Heart murmur Anglina Heart murmur Arteriosclerosis Heart murmur Aretrosclerosis Mit al valve p	0 0 0		
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Diabetes. If yes, specify below:	Ū		
Substanting too, specing below.			
		D	
Dry Mouth D D Thyroid problems			9
			C
	0		<u>а</u>
Fainting spells or seizures D D Do you have any disease, condition, or problem			
not listed above that you think I should know about?	o I		ü
G.E. Reflux/persistent heartburn			
NOTE: Both Doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment. I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the comple		hold	my s form.
IGNATURE OF PATIENTALEGAL GUARDIAN DATE	ll not		

FOR CON	APLETION BY DENTIST
nterview concerning health history:	
n questionnaire or oral interview:	
nsiderations:	
: On a regular basis the patient should be question	oned about any medical history changes, date and comments notated, along with signature.
Comments	Signature of patient and dentist
	n questionnaire or oral interview: n guestionnaire or oral interview: nsiderations: :: On a regular basis the patient should be question

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		LAST		DATE	
FIRST	MI	LAST		STATE/	ZIP/
E-MAIL	CELL PHONE		HOME		. r.c.
SS#/SIN					
CHECK APPROPRIATE BOX:	MINOR SING	F MARRIED	– DIVORCEE		
F COLLEGE STUDENT, F.T. / P.1	I., NAME OF SCHOOL			CITY	STATE/ PROV.
PATIENT'S OR PARENT'S/GUAR	DIAN'S EMPLOYER			WORK PHONE	
PATIENT'S OR PARENT'S/GUAR		CITY		STATE/ PROV.	ZIP/ P.C
SPOUSE OR PARENT'S/GUARD					
WHOM MAY WE THANK FOR R					
PERSON TO CONTACT IN CASI					
RESPONSIBLE PARTY					
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X SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

PATIENT NUMBER

REGISTRATION

Manor College Manor Dental Health Center Dental History

NAME____

DATE_____

ADDRESS_____

1	Reason for this appointment	
2	When was your last dental appointment?	What was done?
3	How often do you visit the dentist?	
4	When was your last dental cleaning?	
5	When were your last dental x-rays taken?	How many? What type?
6	Are you experiencing any dental discomfort or have a dental condition requiring immediate attention? If yes, please explain	
7	If you could change <u>anything</u> about your smile, what would you change?	

		YES	NO	COMMENTS
8	Do your gums bleed?			
9	Do any of your teeth feel loose?			
10	Do you feel you have bad breath?			
11	Do you have any unpleasant taste in your mouth?			
12	Are your teeth sensitive to:			
	Temperature (heat, cold)?			
	Sweet-sour?			
	Pressure?			
13	Does food get caught between your teeth?			
14	Do you have any sore spots or lumps in or around your mouth?			
15	Does your jaw click, pop, or slide or hurt on opening, closing or chewing?			
16	Do you clench or grind your teeth?			
17	Do you or have you worn any dental appliances? (orthodontic, dentures, bite guards)			Туре:
18	Do you have dental implants?			Туре
_	Name of dentist who placed them:			51.5
19	Have you ever had periodontal (gum) treatment?			Туре:
20	Have you ever had orthodontic treatment (braces)?			When? How long?
21	Do you frequently bite your lips or cheeks?			TIOW IONG?
21	Do you frequently bite your lips of cheeks?			
22	Have you had problems associated with past dental work?			prolonged bleeding difficulty getting numb unhappy with over- all dental care other, please specify

3/07; 8/07

		YES	NO	COMMENTS
23	Have you had adverse reactions to local anesthetics or latex			
	gloves?			
24	Do you presently take, or have you in the past taken:			
	Fluoride tablets/supplement?			
	Vitamins with fluoride?			
	Fluoridated water?			
	Herbal supplements?			
	Vitamin/mineral supplements?			
25	Do you use any of the following fluoride products?			
	Fluoride mouthrinse			
	Toothpastes with fluoride			
	Brush-on fluoride gels			
26	Do you ever:			
	Clench or grind your teeth?			
	Chew on one side?			
	Breathe through your mouth?			
	Use chewing tobacco or snuff?			
	Other oral habits (bite nails or foreign objects, suck			
	fingers, etc)? (Circle one)			
27	Do you play contact sports?			
28	Do you wear a mouthguard?			
29	What type of oral health care aids to you use? Please list type a	and freque	ancy?	
30	How frequently do you "snack"? Number of times per day:			
30 31	How frequently do you "snack"? Number of times per day: Please list types of snacks you prefer:			
31	Please list types of snacks you prefer:	ld be?		
31 32	Please list types of snacks you prefer: How long do you think you can keep your teeth?	ld be?		
31 32 33	Please list types of snacks you prefer: How long do you think you can keep your teeth? If you were to lose your teeth, what do you think the cause wou	ld be?		

3/2007; 8/07