

Dental History

Are you happy with your smile? <input type="checkbox"/> Yes <input type="checkbox"/> No	Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No
Reason for today's visit _____ _____	Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing <input type="checkbox"/> Yes <input type="checkbox"/> No
Former Dentist _____ _____	Cigarette, pipe, or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date and duration of treatment _____
City/State _____	Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of last dental visit _____	Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of last dental x-rays _____	Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No	
Bad Breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Food collection between teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding Gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Foreign objects <input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No
	Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No
	Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No
	Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No
	Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in mouth <input type="checkbox"/> Yes <input type="checkbox"/> No
How often do you floss? _____ How often do you brush? _____		
Have you ever had any complications or excessive bleeding following dental treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please explain _____		

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit should be extended. I further agree that the reasonable value of said services shall be as billed unless objected to by me in writing within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees, collection fees and court costs if suit should be instituted hereunder.

I grant my permission to you or your assignee to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and payment and agree to their content.

- I acknowledge that I was given a copy of the privacy notice
- I acknowledge that I declined the copy of the privacy notice that was offered

Signature of patient, parent or guardian

Date

Relationship to Patient

Signature of guarantor of payment/responsible party

Date

Relationship to Patient

Doctor's Signature

Date

*COMPREHENSIVE
DENTAL
CARE*

Oscar Menendez, D.D.S., P.A.

Health History

Have you ever had any of the following? Please check all that apply:

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> AIDS / HIV | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Endocarditis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Arthritis / Rheumatism | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Artificial Joints (knee/hip) | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood Disease/Abnormal Bleeding | <input type="checkbox"/> Growths | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Cancer or Tumors | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Heart Conditions | Due date: _____ | <input type="checkbox"/> OTHER: _____ |
| <input type="checkbox"/> Diabetes | Diagnosis _____ | <input type="checkbox"/> Pulmonary | |
| Last AIC _____ | <input type="checkbox"/> Heart Murmur / Mitral Valve Prolapse | DS Type _____ | |
| | | <input type="checkbox"/> Psychiatric Care | |

Name of Physician _____ Phone _____

Please list all medications _____

- Allergies: Aspirin Iodine Penicillin Other
 Barbiturates (sleeping pills) Latex Sulfa
 Codeine Local Anesthetic

Signature of patient, parent or guardian _____

Date _____

Updates (to be filled in at future appointments)

Has there been any change in your health since your last dental appointment? Yes No

If yes, for what conditions? _____

Are you taking any new medications? Yes No If yes, what? _____

Patient's Signature _____ Date _____

Has there been any change in your health since your last dental appointment? Yes No

If yes, for what conditions? _____

Are you taking any new medications? Yes No If yes, what? _____

Patient's Signature _____ Date _____

Has there been any change in your health since your last dental appointment? Yes No

If yes, for what conditions? _____

Are you taking any new medications? Yes No If yes, what? _____

Patient's Signature _____ Date _____

Has there been any change in your health since your last dental appointment? Yes No

If yes, for what conditions? _____

Are you taking any new medications? Yes No If yes, what? _____

Patient's Signature _____ Date _____