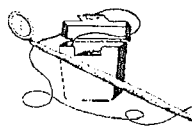


DENTAL HISTORY



Essex Family Dental

J. Allen Feeley, D.D.S., P.C.

PATIENT NAME
DATE

Welcome! So that we may provide you with the best possible care, please complete both sides of this medical/dental history form. All information is completely confidential.

What is the reason for your visit today?

Date of Last Dental Visit Last Dental Cleaning Last Full Mouth X-Rays

What was done at your last dental visit?

Previous Dentist's Name State Zip

Address Telephone

How often do you have dental examinations?

How often do you brush your teeth? How often do you floss?

What other dental aids do you use? (Interplak, toothpick, etc.)

Do you have any dental problems now? Yes No

If yes, please describe:

Are any of your teeth sensitive to:

Hot or cold? Sweets? Biting or Chewing? Have you noticed any mouth odors or bad tastes? Do you frequently get cold sores, blisters or any other oral lesions?

Do your gums bleed or hurt?

Have your parents experienced gum disease or tooth loss? Have you noticed any loose teeth or change in your bite? Does food tend to become caught in-between your teeth?

If yes, where?

Do you:

Clench or grind your teeth while awake or asleep? Bite your lips or cheeks regularly? Hold foreign objects with your teeth? Mouth breathe while awake or asleep? Have tired jaws, especially in the morning? Smoke/chew tobacco?

Have you ever had:

Orthodontic treatment or braces? Oral surgery or your wisdom teeth removed? Periodontal treatment or gum disease? Your teeth ground or the bite adjusted? A bite plate or mouth guard? A serious injury to the mouth or head?

If so, please describe, including cause

Have you experienced:

Clicking or popping of the jaw? Pain? Difficulty in opening or closing the mouth? Difficulty in chewing on either side of the mouth? Sore muscles (neck, shoulders)?

Are you satisfied with your teeth's appearance?

Would you like to keep all of your teeth all of your life? Are straight teeth important to you? Do you feel nervous about having dental treatment? If so, what is your biggest concern?

Have you ever had an upsetting dental experience?

If yes, please describe

Dental Review
Dentist Signature Date

Form 2 (9/95)

(Please complete other side)

by permission of The Pride Institute

MEDICAL HISTORY

PATIENT NAME

1. Physician's Name Phone Address City State Zip

Have you been under the care of a medical doctor during the past two years? If yes, for what?

2. Have you taken any medication or drugs during the past two years?

3. Are you taking any medication, drugs or pills now? If yes, please list name and dosage

3a. Have you taken any recreational drugs in the past two years?

4. Are you aware of having an allergic (or adverse reaction) to any medication or substance? If yes, please list:

5. Have you been a patient in the hospital during the past five years?

6. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each of them.

Heart (Surgery, Disease, Attack) Chest Pain Congenital Heart Disease Heart Murmur High Blood Pressure Mitral Valve Prolapse Artificial Heart Valve Heart Pacemaker Rheumatic Fever Arthritis/Rheumatism Cortisone Medicine Swollen Ankles Stroke Diet (Special/Restricted) Artificial Joints (hip, knee, etc) Kidney Trouble Ulcers Diabetes Thyroid Problems Glaucoma Contact lenses Emphysema Chronic Cough Tuberculosis Asthma Hay Fever Latex Sensitivity Allergies or Hives Sinus Trouble Radiation Therapy Chemotherapy Tumors Hepatitis A (infectious) B (serum) Venereal Disease A.I.D.S. H.I.V. Positive Cold Sores/Fever Blisters Blood Transfusion Hemophilia Sickle Cell Disease Bruise Easily Liver Disease Yellow Jaundice Neurological Disorders Epilepsy or Seizures Fainting or Dizzy Spells Nervous/Anxious Psychiatric/Psychological Care

7. Do you snore or have difficulty sleeping?

8. Do you have headaches?

9. Have you lost or gained more than 10 pounds in the past year?

10. Do you have or have you had any disease, condition, or problem not listed? If yes, please list:

11. Women. Are you: Pregnant? Yes, ___ Months No Nursing? Yes No

11a. Taking birth control pills? Yes No

*WARNING: Be aware that if you take an antibiotic, it may cause the birth control pill to be ineffective.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Parent/Guardian Signature Date

History Review
Dentist Signature Date

Form 2 (9/95)

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