

## Essex Family Dental J. Allen Feeley, D.D.S., P.C.

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.

Allega viceI-	3.40	Lasi	Dental C	leaning	9		Last Full Mouth X-Rays		_
What was done at your last dental v	visit?								
Previous Dentist's Name							StateZ	n	
Address					·			۲ <u> </u>	
Telephone									
<b>How often do you have dental ex</b> How often do you brush your teeth?					How often do	vou fla	oss?		
What other dental aids do you use?	(Interpla	ık, tooth	oick, etc.)			you no			
Do you have any dental problems	s now?		Yes	No					-
If yes, please describe:	*								
Are any of your teet			Yes	No			Have you ever had		
	Sv	r cold? weets?	Yes	No No	0	ral sur	Orthodontic treatment or braces' gery or your wisdom teeth removed'		
Biting Have you noticed any mouth odors	ng or Che s or bad t	_	Yes Yes	No No			riodontal treatment or gum disease' ur teeth ground or the bite adjusted'		
Do you frequently get cold s any oth	ores, blis er oral le		Yes	No			A bite plate or mouth guard' serious injury to the mouth or head'	Yes	
•			Voo	Nio	If so, please		be, including cause		
<b>Do your gums</b> Have your parents experience	ed gum d	lisease	Yes	No			7.0	-	
Have you noticed any loose	or tooth teeth or c		Yes	No			Have you experienced Clicking or popping of the jaw'		ı
Does food tend to become car	in you	ur bite?	Yes	No		Diffic	Pain? (joint, ear, side of face	) Yes	
	your	teeth?	Yes	No	Difficu		ulty in opening or closing the mouth' chewing on either side of the mouth'	? Yes	
If yes, where?							Sore muscles (neck, shoulders)	? Yes	
Clench or grind your teeth while av		o you:	Yes	No			fied with your teeth's appearance' keep all of your teeth all of your life'		
Bite your lips or ch Hold foreign objects	eeks reg	jularly?	Yes Yes	No No	Ave st	Henry	ht tests importent t	5 40 h	
(pencils, pipe, pins, n	ails, finge	ernails)	Yes	No	Do you fe	eei ner	vous about having dental treatment		
Mouth breathe while av Have tired jaws, especially		•	Yes Yes	No No	Have voi	ı ever	had an upsetting dental experience	- ? Yes	
	/chew tob		Yes	No		s, plea	ase describe	-	
Dental Review								-	
Dentist Signature				·· <del>·</del> ····			Date		
Form 2 (9/95)		(	Please	comp	lete other si	de)	by permissi	on of The P	ride Ins
					7		MEDICAL HI	STOP	RY.
ATIENT NAME							medical Hi	STOF	₹Y
								STOP	₹Y
			City		Phone				3Y
Physician's Name	a medica	ıl doctor	City _	e past tv					No.
Physician's Name Address Have you been under the care of	a medica	ıl doctor	during the	past tv	wo years?	•••••	State Zip	. Yes	No
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Physician's Name  Address  Have you been under the care of If yes, for what?  Have you taken any medication of Are you taking any medication, drif yes, please list name and dosage. Have you taken any recreational of Are you aware of having an allerg If yes, please list:  Have you been a patient in the hould indicate which of the following you seart (Surgery, Disease, Attack)	a medica r drugs du ugs or pill ge	uring the last verse reading the past verse reading the lad, or ha Ulcers Diabet Thyroi Glauco Conta Emphy Chron Tubero Asthm Hay F Latex Allergi Sinus Radia Chem Tumor Tumor Intibiotic Interessal Chem Tumor Intibiotic Interessal Chem Tumor Intibiotic Interessal Chem Intibiotic Intibiotic Interessal Chem Intibiotic Interessal Chem Intibiotic	during the epast two wears five years five years five years five years five at present five for the past five years five for the five for the past years for the past years for province for the past years for province for the past years for t	years?  ?  any med  /ears?  sent. Ci  sent. Ci  Note any med  /ears?  //ears?  //ear	dication or substanticle "yes" or no" to yes	nce?	State Zip  To of them.  Hepatitis A (infectious) B (serum)	Yes	No N
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Physician's Name  Address  Have you been under the care of If yes, for what?  Have you taken any medication of Are you taking any medication, drif yes, please list name and dosage. Have you taken any recreational of Are you aware of having an allerg If yes, please list:  Have you been a patient in the hould indicate which of the following you have Prolapse.  Have you been a patient in the hould indicate which of the following you have head aches?  Have you been a patient in the hould indicate which of the following you have head aches?  Have you been a patient in the hould indicate which of the following you have head aches?  Have you been a patient in the hould indicate which of the following you have head aches?  Have you have head aches?  Have you have or have difficulty slightly s	a medica r drugs du ugs or pill ge	uring the uring the past verse reading the ad, or had Ulcers Diabet Thyroid Glauce Contain Emphy Chron Tubert Asthm Hay F Latex Allergis Sinus Radiain Chem Tumor	during the e past two we are past five you at present the second of the past five you at present the second of the past years of the past	years? ? any med years? sent. Ci	dication or substanticle "yes" or no" to yes	nce?	State Zip  Tof them.  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  be ineffective.  In a safe and efficient manner.  be needed, you have my permation to you. I will notify the docase.	Yes	No N
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