Health History Update

Name_____ Email Address _____

SINCE YOUR LAST VISIT: has any of the following information changed? If so, please list:

1. Address: _____
2. Phone Number: _____ Work Phone Number: _____Cell Phone #_____
3. Insurance Company: _____ 4. Employer: _____

SINCE YOUR LAST VISIT:			Describe
1. Have you been a patient in a hospital?		Yes___ No ___	_____
2. Have you been under the care of a physician?		Yes___ No ___	_____
3. Has your health changed?		Yes___ No ___	_____
4. WOMEN:	Are you pregnant?	Yes___ No ___	
	Are you nursing?	Yes___ No ___	

CIRCLE ANY OF THE FOLLOWING YOU HAVE EVER HAD:

alcoholism	drug addiction	HIV/AIDS	seizures
anemia	emphysema	joint replacement	sinus problems
angina	excessive bleeding	kidney problem	stomach problems
asthma	glaucoma	liver problem	stroke
blood problem	heart murmur	lung disease	surgery_____
cancer	heart problems	mitral valve prolapse	surgical pins/plates
chemotherapy	heart surgery	osteoporosis	thyroid problem
cold sores	heart valve problem	pacemaker	tuberculosis
congenital heart problem	hepatitis	psychiatric treatment	ulcers
diabetes	herpes	radiation therapy	other_____
dizziness/fainting	high blood pressure	rheumatic fever	

1. List all current medications (including vitamins, birth control pills and pain relievers): _____
   _____
2. List any allergies_____
3. Physician's name:_____ Date of last exam:_____

I certify that the above is correct to the best of my knowledge. I will not hold the dentists or their staff responsible for errors or omissions that I may have made in the completion of this form.

I understand that I am financially responsible for all costs of dental treatment, including any charges not covered or paid for by my insurance company, or any additional dentistry that may be necessary during treatment. I also understand that unless I give 24 hrs. notice, I will be charged $50 per half-hour for an appointment that is not kept. I authorize release (including electronic) of any information relating to treatment. I understand that the information will be sent either by mail or in unencrypted electronic form and there is some risk that third parties might be able to access this data. I hereby assign payment of my insurance company benefits otherwise payable to me directly to John L. Little, D.D.S., P.A.

PATIENT_____ DENTIST Sig_____

GUARDIAN_____ WITNESS _____

DATE _____

Dental History

Name_____Date_____

1. When was your last dental appointment?_____

2. What was done?_____

3. Are you having any pain or discomfort?_____

4. Do you feel nervous or anxious regarding dental treatment? Yes No
   Are you interested in learning about nitrous oxide relaxation therapy? Yes No

5. Have you ever had a bad experience in a dental office? Yes No

6. Do you clench or grind your teeth? Yes No

7. Does your jaw ever click or hurt when chewing or opening? Yes No

8. Do you have old filings or dental work that you don't like looking at? Yes No

9. Is there anything about your teeth that you wish you could change? Yes No

10. If so, what would it be? _____

11. Are you interested in learning about:
    Professional tooth whitening? Yes No
    Tooth colored fillings? Yes No
    Cosmetic Bonding/Veneers (to restore stained or chipped teeth) Yes No
    (to close spaces between teeth)

12. Are you interested in learning about:
    Invisalign (a technique to straighten teeth without braces)? Yes No
    Orthodontics(to straighten or close spaces between teeth)? Yes No

13. Are you interested in learning about Implants Yes No
    (to replace missing teeth, make dentures more stable)
    and/or eliminate dentures)

14. Do you snore? Yes No
    Do you have Sleep Apnea? Yes No
    Do you wear a CPAP? Yes No

15. Do you smoke? Yes No
    If yes, approximately how much per day?_____
    Do you chew tobacco? Yes No

16. Please list other questions, concerns or comments that you have about your mouth and oral health._____
    _____