ADULT HEALTH AND PERSONAL HISTORY UPDATE

PLEASE FILL OUT PRIOR TO EACH CLEANING APPOINTMENT

Name_____**Date of Birth**_____

Marital status □ Married □ Divorced □ Separated □ Single

□ Yes □ No 1. Do you have any medical concerns/problems? (allergies, diabetes, heart/lung disorders, etc.)

_____

□ Yes □ No 2. Are you taking any medication at this time? What & Why?

_____

□ Yes □ No 3. Have you ever had surgery or been hospitalized? If so, for what?

_____-_____

□ Yes □ No 4. Are any areas of your mouth, head, or neck causing pain or discomfort? If so, where & when?

_____

□ Yes □ No 5. Do you have any questions or concerns regarding your oral health? If yes, what?

_____

□ Yes □ No 6. May we take bitewing x-rays (cavity detecting x-rays) on you today, if needed?

□ Yes □ No 7. May we take a panoramic x-ray (growth & development x-ray) today, if needed?

□ Yes □ No 8. May we give you a fluoride treatment today? (May or May NOT be covered by insurance)

□ Yes □ No 9. Are you interested in bleaching your teeth?

We welcome any comments or suggestions about our office. Your advice is appreciated. Thank You.

Signature: _____Date: _____

Cell_____