



C. Michael Bennett, D.D.S., F.A.G.D., P.C.
David A. Bennett, D.D.S.

HEALTH INFORMATION

Patient Name: _____ Date: _____

DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

- Bad breath Yes No
 Bleeding gums Yes No
 Blisters on lips or mouth Yes No

- Burning sensation on tongue Yes No
 Chew on one side of mouth Yes No
 Cigarette, pipe, or cigar smoking Yes No
 Clicking or popping jaw Yes No
 Dry mouth Yes No
 Fingernail biting Yes No
 Food collection between the teeth Yes No
 Foreign objects Yes No
 Grinding teeth Yes No
 Gums swollen or tender Yes No
 Jaw pain Yes No
 Lip or cheek biting Yes No

- Loose teeth or broken fillings Yes No
 Mouth breathing Yes No
 Mouth pain, brushing Yes No
 Orthodontic treatment Yes No
 Periodontal treatment Yes No
 Sensitivity to cold Yes No
 Sensitivity to heat Yes No
 Sensitivity to sweets Yes No
 Sensitivity when biting Yes No
 Sores or growths in your mouth Yes No
 How often do you floss? _____
 How often do you brush? _____

HEALTH HISTORY

Physician's Name _____ Date of Last Visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (Brand names of phentermine), Pondimin (fenfluramine) and Redux (Dexfenfluramine). Yes No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

- AIDS/HIV Yes No
 Anemia Yes No
 Arthritis, Rheumatism Yes No
 Artificial Heart Valves Yes No
 Artificial Joints Yes No
 Asthma Yes No
 Back Problems Yes No
 Bleeding abnormally, with extractions or surgery Yes No
 Blood Disease Yes No
 Cancer Yes No
 Chemical Dependency Yes No
 Chemotherapy Yes No
 Circulatory Problems Yes No
 Congenital Heart Lesions Yes No
 Cortisone Treatments Yes No
 Cough, persistent or bloody Yes No
 Diabetes Yes No
 Do you wear contact lenses? Yes No
 Emphysema Yes No

- Epilepsy Yes No
 Fainting or Dizziness Yes No
 Glaucoma Yes No
 Headaches Yes No
 Heart Murmur Yes No
 Heart problems Yes No
 Hepatitis Type A B C Yes No
 Herpes Yes No
 High Blood Pressure Yes No
 Jaundice Yes No
 Jaw Pain Yes No
 Kidney Disease Yes No
 Liver Disease Yes No
 Low Blood pressure Yes No
 Mitral Valve Prolapse Yes No
 Nervous Problems Yes No
 Pacemaker Yes No
 Psychiatric Care Yes No
 Radiation Treatment Yes No
 Respiratory Disease Yes No
 Rheumatic Fever Yes No

- Scarlet Fever Yes No
 Shortness of Breath Yes No
 Sinus Trouble Yes No
 Skin Rash Yes No
 Special Diet Yes No
 Stroke Yes No
 Swollen Feet or Ankles Yes No
 Swollen Neck Glands Yes No
 Thyroid Problems Yes No
 Tonsillitis Yes No
 Tuberculosis Yes No
 Tumor or growth on head or neck Yes No
 Ulcer Yes No
 Venereal Disease Yes No
 Weight Loss, unexplained Yes No

Women:

Are you pregnant? Yes No

Due Date _____

Are you nursing? Yes No

Taking birth control pills? Yes No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis: _____

Pharmacy Name _____

Phone (_____) _____

ALLERGIES

Aspirin

Barbiturates (Sleeping Pills)

Codeine

Iodine

Latex _____

Local Anesthetic

Penicillin

Sulfa

Other _____

The above information is accurate and complete to the best of my knowledge. I will not hold Dr. Bennett and associates or any member of their staff responsible for any errors or omissions that I may have made in the completion of this form. I request and consent to all procedures which I may require, and understand that procedures in dental treatment are not an exact science and no guarantees as to the outcome of treatment will be offered -only that Dr. Bennett and associates will exercise their professional expertise and ability in my best interest, according to their best judgement.

Signature _____ Date _____

UPDATES

(to be filled in at future appointment)

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

For what conditions? _____

Are you taking any new medications? _____ If so, what _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

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

For what conditions? _____

Are you taking any new medications? _____ If so, what _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

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

For what conditions? _____

Are you taking any new medications? _____ If so, what _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____