



**MEDICAL HISTORY**

Are you currently under a physician's care? \_\_\_\_\_ for what condition: \_\_\_\_\_

Dr.'s Name: \_\_\_\_\_ Dr.'s Phone No. \_\_\_\_\_

Have you had any serious illness or operation? \_\_\_\_\_ if yes, please describe: \_\_\_\_\_

Have you ever had a blood transfusion? \_\_\_\_\_ If yes, approximately when? \_\_\_\_\_

For women: Are you pregnant? \_\_\_\_\_ Nursing? \_\_\_\_\_ Taking Birth Control Pills? \_\_\_\_\_

**CIRCLE IF YOU HAVE HAD ANY OF THE FOLLOWING:**

Rheumatic Fever	Y	N	Heart Problem	Y	N	Heart Murmur	Y	N
Pacemaker/Heart Surgery	Y	N	Artificial Heart Valves	Y	N	Shortness of Breath	Y	N
Surgical Implants	Y	N	Low Blood Pressure	Y	N	High Blood Pressure	Y	N
Stroke	Y	N	Fainting/Dizziness	Y	N	Headaches	Y	N
Epilepsy	Y	N	Kidney Disease/Malfunction	Y	N	Swelling of the Feet/Ankle	Y	N
Persistent Cough	Y	N	Tuberculosis	Y	N	Sinus Problem	Y	N
Cough Up Blood	Y	N	Respiratory Disease	Y	N	Tobacco Habit	Y	N
Blood Disease	Y	N	Liver Disease	Y	N	Hepatitis	Y	N
Anemia	Y	N	Cancer	Y	N	Radiation Therapy	Y	N
Chemotherapy	Y	N	Diabetes	Y	N	Parathyroid Disease	Y	N
Thyroid Disease	Y	N	Stomach Ulcers/Colitis	Y	N	Skin Rash	Y	N
Food Allergies	Y	N	Anaphylaxis	Y	N	Metallic Allergies	Y	N
Back Problems	Y	N	Nervous Problems	Y	N	Psychiatric Care	Y	N
AIDS/HIV Positive	Y	N	Herpes/Genital Herpes	Y	N	Veneral Disease	Y	N
Cortisone Treatment	Y	N	Rapid Weight Gain/Loss	Y	N	Glaucoma	Y	N
Arthritis	Y	N	PHEN-FEN	Y	N	Latex Sensitivity	Y	N

**List Any Medications You Are Currently Taking:**

**Allergies, If Any:**

\_\_\_\_\_

**AUTHORIZATION**

I have reviewed the information on this questioner, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there are any changes to my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I authorize the dentist to release all information necessary to secure the payment whether or not paid by insurance. I understand that I am responsible for all charges incurred whether or not paid by insurance.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Doctor's Signature

\_\_\_\_\_  
Date

**I HAVE READ THE COPY PROVIDED OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA).**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# Elegant Smile Dental

## BEHAVIORAL/TREATMENT PLANNING CONSULTATION FORM

WE REALIZE THAT MANY PEOPLE ARE NERVOUS OR FRIGHTENED ABOUT GOING TO THE DENTIST. IF YOU HAVE SUCH FEELINGS WE WOULD LIKE TO HELP YOU. PLEASE ANSWER THESE QUESTIONS CAREFULLY. THIS INFORMATION WILL MAKE YOUR DENTAL EXPERIENCE MORE COMFORTABLE. PLEASE CHECK THE ANSWER THAT BEST DESCRIBES YOUR FEELINGS. THANK YOU FOR YOUR COOPERATION.

1. IF YOU HAD TO GO TO THE DENTIST TOMORROW, HOW WOULD YOU FEEL ABOUT IT?  
 I WOULD LOOK FORWARD TO IT AS A REASONABLY ENJOYABLE EXPERIENCE.  
 I WOULDN'T CARE ONE WAY OR THE OTHER.  
 I WOULD BE A LITTLE UNEASY ABOUT IT.  
 I WOULD BE AFRAID THAT IT WOULD BE UNPLEASANT AND PAINFUL.  
 I WOULD BE VERY FRIGHTENED OF WHAT THE DENTIST MIGHT DO.
  
2. WHEN YOU ARE WAITING IN THE DENTAL OFFICE FOR YOUR TURN IN THE CHAIR, HOW DO YOU FEEL?  
 RELAXED  
 TENSE  
 A LITTLE UNEASY  
 ANXIOUS  
 SO ANXIOUS THAT I SOMETIMES BREAK OUT IN A SWEAT OR ALMOST FEEL PHYSICALLY SICK.
  
3. WHEN YOU ARE IN THE DENTIST'S CHAIR WAITING WHILE HE GETS HIS INSTRUMENTS READY TO BEGIN WORKING ON YOUR TEETH, HOW DO YOU FEEL?  
 RELAXED  
 TENSE  
 A LITTLE UNEASY  
 ANXIOUS  
 SO ANXIOUS THAT I SOMETIMES BREAK OUT IN A SWEAT OR ALMOST FEEL PHYSICALLY SICK.
  
4. YOU ARE IN THE DENTIST'S CHAIR TO HAVE YOUR TEETH CLEANED. WHILE YOU ARE WAITING AND THE DENTIST IS GETTING OUT THE INSTRUMENTS, WHICH HE WILL USE TO CLEAN YOUR TEETH AROUND THE GUMS, HOW DO YOU FEEL?  
 RELAXED  
 TENSE  
 A LITTLE UNEASY  
 ANXIOUS  
 SO ANXIOUS THAT I SOMETIMES BREAK OUT IN A SWEAT OR ALMOST FEEL PHYSICALLY SICK.
  
5. HAVE YOU EVER BEEN TENSE OR NERVOUS ABOUT YOUR DENTAL THERAPY? \_\_\_YES\_\_\_NO
  
6. HAS LOCAL ANESTHETIC EVER FAILED TO WORK FOR YOU? \_\_\_YES\_\_\_NO
  
7. HAVE YOU TRIED NITROUS OXIDE (LAUGHING GAS)?\_\_\_YES\_\_\_NO
  
8. WAS NITROUS OXIDE SUFFICIENT TO ALLEVIATE YOUR ANXIETY?\_\_\_YES\_\_\_NO
  
9. HAVE YOU EVER HAD INTRAVENOUS SEDATION OR GENERAL ANESTHESIA IN A DENTAL OFFICE?\_\_\_YES\_\_\_NO
  
10. WAS SEDATION SUFFICIENT TO ALLEVIATE YOUR PAIN?\_\_\_YES\_\_\_NO
  
11. WOULD YOU LIKE A CONSULTATION WITH OUR DENTIST TO DISCUSS SPECIFIC WAYS TO ALLEVIATE PAIN ANXIETY FOR ALL FORMS OF DENTAL THERAPY?\_\_\_YES\_\_\_NO