BOISE CARING DENTISTRY

Veronica Montgomery, D.D.S., AIAOMT

Welcome to our office!

It is our commitment to provide optimal service to our patients. As a part of that commitment, it is necessary for us to compile very precise, detailed information regarding your conditions and symptoms. The forms included in this packet asks specific questions necessary to arrive at a complete diagnosis and treatment plan designed specifically for you.

After completing the forms in this packet, please bring them with you to your first appointment. Please understand that if you do not bring these forms prior to your appointment, we will not be able to complete your exam at your appointed time and we may have to schedule another follow up visit.

***Please wear comfortable clothing so that your neck is easily exposed.** Clothing needs to fit well to show your posture. Please do not wear turtlenecks or baggy clothes. Wear shoes that are comfortable and comparable to the shoes you wear most of the time.*

*We ask that you **do not bring children to your dental appointments.** Children can interfere with our ability to provide you with timely comprehensive dental care as well as be disruptive to other patients. We kindly ask that you make other arrangements for childcare during your dental appointments.*

*We are a **Fragrance free Dental Practice**. We have found many fragrances and colognes to be highly allergic to several of our employees. We hope you will understand our plight and avoid the use of perfumes, colognes and fragrant body sprays and lotions when visiting our office.*

Thank you for choosing to trust Boise Caring Dentistry with your care. We look forward to your visit. If you have any questions about any of the forms or financial policies of our office, feel free to contact us. We look forward to meeting you!

Sincerely,

Boise Caring Dentistry

Signature of Patient, Parent or Guardian: ____Date: ____________________

BOISE CARING DENTISTRY
Veronica Montgomery, D.D.S., AIAOMT

Dear Guest:

We appreciate the trust you have placed in us by choosing to receive your oral care here at Boise Caring Dentistry.

As we strive to provide comprehensive dental treatment using current technology and protocols, our practice is growing. With this growth, it is our desire to continue providing high quality treatment without having to wait weeks on end for an available appointment.

*A fee of **$50** will be charged for any cancellations, broken appointment, or reappointments **UNLESS** at least a **48 hour** of notice has been given. **$50** will also be charged if a patient is more than 15 minutes late for his/her appointment and must be rescheduled.*

*Every patient is given priority **while being treated**. If **WE** are running more than 10 minutes late, you will be given the opportunity to reschedule with no penalty. It is difficult to predict what may happen during a procedure, and sometimes things happen that are beyond our control.*

We appreciate your understanding as we strive to improve access to comprehensive care and prompt treatment here at Boise Caring Dentistry.

Sincerely,

Boise Caring Dentistry

By signing below, I agree to the above appointment cancellation and late arrival policy.

Signature of Patient, Parent or Guardian: ____Date: _____________________

BOISE CARING DENTISTRY
Veronica Montgomery, D.D.S., AIAOMT

Individual Information

First Name: _______________________ Middle Initial: _____ Last Name: ______________________

Parent or Guardian: _________________________________

Female ____ Male ____

Preferred Name: __________________

Height: ___________ Weight: _________ lbs

Address: ____

City: _______________________________State:________ Zip: ______________

Home phone: ___________________________ Work phone: ________________________________

Cell phone: ___________________________

Birth date: _____/_____/_____

SS#_______________________

Marital status: Single ____ Married ____ Divorced ____ Widowed ____ Student ____

E-mail address: ____

Who can we thank for referring you? ____

Emergency Information

I give permission for Boise Caring Dentistry to share my medical and account information with:

Person to contact: ____

Relationship: ___________________________________ Phone: _______________________________

Signature of Patient, Parent or Guardian: ____***Date:*** ____________________

“Limited” Diagnostic Records

Diagnosis is key to any successful treatment. As you are presenting with no craniofacial or sleep disorders of which you are aware, our records appointment will be “limited” to the following records. If it is determined that there are underlying disorders and or conditions beyond which the “limited” records will allow us to see, other records/tests may be indicated and recommended.

1. **Records Appointment**
   Information is gathered in order to make a thorough assessment and diagnosis. This Includes:

PROCEDURES	ADA CODE	MED CODE	COST
COMPREHENSIVE ORAL EXAM	0150	99203	$105.00
FMX DIGITAL RADIOGRAPHS- ALL TEETH	0210	70320	$154.00
OROFACIAL AND POSTURE IMAGES	0350	99070	$45.00
NUTRITIONAL SCAN	NS		$25.00
DIGITAL IMPRESSIONS	0470	99070	$35.00
ORAL CANCER PHOSPHORSESCENCE	0482	02431	$25.00
3D DIGITAL PANORAMIC IMAGE	0367	70355	$101.00
CONE BEAM INTERP & REPORT	00391		$125.00
VITAMIN D TEST	VITD		$35.00
HEART RATE VARIABILITY	HRV		$25.00
MEAS (MERIDIAN BALANCE TESTING	MEAS		$25.00

TOTAL DIAGNOSTIC FEE $ 700.00

2. **Consultation Appointment**

   Should more than 1-2 simple fillings be required to restore your orofacial system to health, Dr Montgomery will analyze your records and create a customized care plan. The fee listed is for care plan creation and accompanying consultation appointment. As it can take Dr Montgomery up to 2 hours to complete your treatment plans, this fee must be prepaid prior to Dr. Montgomery reviewing all your records. **COST $175**

Payment of Fees

If you have dental insurance, some of these may be reimbursable. Regardless of insurance coverage ***payment for services rendered are due at the time of service.*** I understand that there is a **NON-REFUNDABLE** $200 deposit to reserve a diagnostic appointment.

By signing below, I attest that I understand and agree to the above-listed procedures and associated fees.

Signature of Patient, Parent or Guardian: ____Date: _____________________

FINANCIAL POLICY

We appreciate the trust you have placed in us by choosing our dental practice. In order to make your experience smooth and pleasant, we ask that you read and acknowledge our financial policy.

Payment is due at the time of service. Cash and personal checks are accepted. A $25 fee will be charged for returned checks. If an extended payment plan is desired, please ask your credit union. We also accept all major credit card. If you have any questions, please feel free to ask.

INITIAL HERE __________

I understand and agree that all services rendered to me and my dependents or others assigned by me to my account are charged directly to me. I further understand I am personally responsible for payment. If I suspend or terminate care and treatment, any fee for services rendered will be immediately due and payable.

INITIAL HERE __________

I understand that if I make an appointment, I am responsible for keeping that appointment. In the event that I cannot make an appointment, I understand that I must provide at least 48 hour notice. If an appointment of 2 hours or greater is necessary, I agree to pay $200 to reserve that appointment. I understand that the $200 will be applied toward the cost of treatment provided during the appointment.

INITIAL HERE __________

We suggest and encourage you to discuss office visits and procedural costs at the time of service to avoid misunderstandings. Failure to do so does not absolve you of responsibility for charges incurred.

INITIAL HERE __________

If you have insurance…

As a courtesy, we will provide a “suberbill” at the conclusion of your treatment. You may submit this form directly to your insurance provider. Any payments from the insurance company will be sent directly to you. ***Dr Montgomery is not a preferred provider for ANY insurance company.*** You may find that our fees may be different from the insurance company “allowable” fee’s or “UCR” fee’s. If you have questions, please feel free to ask. All services rendered are charged directly to the patient, and the patient is ultimately responsible for the account regardless of insurance coverage. If a claim is denied, or if the insurance does not pay what you thought they would pay, it is **YOUR** responsibility to file an appeal.

Printed Name: ______________________________

Signature of Patient, Parent or Guardian: ____ ***Date:*** ____________________

Patient Photo Release Form

I hereby authorize Dr. Montgomery and/or any of her assignees to take photographs, slides and/or video of my face, jaw and teeth.

I understand that the photographs, slides and/or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising (including website publications), and professional publications (dental magazines and journals).

I do not expect compensation, financial or otherwise, for the use of these photographs, slides or videos.

____
Patient Name

____
Patient/Guardian Signature

____
Date

Signature of Patient, Parent or Guardian: ____Date: _____________________

HIPPA

Notice of Privacy Practice

This notice describes how medical/ dental information about you may be used/disclosed and how you can get access to this Information. Please review it carefully. Our commitment here at Boise Caring Dentistry is to serve our clients with professionalism, assuring at all times the protection of privacy and security of all Protected Health Information. When you receive care from Boise Caring Dentistry we may use your health information for treating you, billing for services and conducting our normal business known as dental care operations. Examples of how we use your information include:

Treatment: We may use and disclose your dental information to plan, provide and coordinate your dental care services. For example, we may make your dental information available to other dental providers for review of treatment options, or to enable them to schedule visits appropriate for your specific treatment.
Payment: We may use and disclose your dental information and records to obtain payment for dental services we have provided for you. For example, we may provide copies of notes and x-rays taken during your visit to your insurance company.
Health Care Operations: We may use disclose your protected health information for our health care operations. For example, we may use or disclose your personal health information to perform risk assessments and other administrative tasks to monitor the quality of care we provide. For uses and disclosures of your personal dental information not involving treatment, payment of health care operations, we will receive your written authorization prior to using or disclosing an personal health information (unless required or permitted by law) You have the right to revoke any authorization previously granted.

We may use disclose your personal health information without obtaining your consent or authorization in the following situations:

- To recommend treatment alternatives
- To tell you about dental services and products that may benefit you.
- To remind you of an appointment
- Share information with family or friends involved in your care or payment for your care provided. You have the opportunity to agree or object to this disclosure. If you are unable to agree or object, we may disclose information as necessary based on our professional judgement.
- For health oversights activities such as investigations, audits, and inspections authorized by law.
- For lawsuits and similar proceeding when we receive satisfactory assurance that appropriate precautions have been taken.
- When requested by law enforcement as required by law or court order.
- When otherwise required by law.

Boise Caring Dentist is Required By Law to:

- Maintain the privacy of your health information.
- Provide this notice that describes the way we may use and share your information.
- Follow the terms of the notice currently in effect.

You Have The Right To:

- Request restrictions on how we use and share your health information. We will consider all requests for restrictions carefully, but are not required to agree to any restrictions.
- Inspect and copy your health information, including dental and billing records. Fees may apply. Under limited circumstances, we may deny your access to portion of your health information and you may request a review of the denial.*

Requests marked with a star (*) must be in writing.
We reserve the right to change our privacy practice and to alter this Notice according to those changes; we will provide a copy of the changes to you at your next scheduled appointment.

I understand and agree to the above described privacy policy.

Printed Name ____

Signature of Patient, Parent or Guardian: ____ ***Date:*** ____________________

Authorization to Release & Discuss Dental Information

The HIPPA privacy law requires that we are only authorized to communicate with patients themselves, guardians, insurance providers and primary care physicians unless we have authorization in writing by the patients to communicate with other on their behalf. Please provide family members or friends you want us to be able to speak with. Spouses are not automatically included; their names must be explicitly stated below.

You may opt out by checking the **"Do not Release Information"** area below.

Name: ______________________________

Relationship: _________________________

Phone number: _______________________

DO NOT RELEASE INFORMATION TO ANYONE: ___

I understand that my express consent is required to release any health care information. With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my healthcare provider(s) should I wish to change one or more contacts listed above.

Signature of Patient, Parent or Guardian: ____*Date:* _____________________

General Informed Consent

I understand that the treatment requiring exams, x-rays, fillings, veneers, gum procedures, periodontal procedures, crown and/or fixed bridgework, extraction and implant placement includes certain risks and possible unsuccessful results, with even the possibility of failure. I agree to assume those risks, possible unsuccessful results and/or failure associated with, but not limited to the following: (Even though care and diligence is exercised in the treatment of the above conditions or treatment, there are no promises or guarantees of anticipated results or the longevity of the treatment).Videos and pictures may be taken for educational purposes and charting but will not be released to the general public.

Reduction of tooth structure: In order to replace decayed or otherwise traumatized teeth it is necessary to modify the existing tooth or teeth so that the filling, veneer, crown (cap), bridge or implant may be placed upon them. Tooth preparation will be done as conservatively as possible.

Sensitivity of teeth: Often after the preparation of teeth for the reception of either crowns or bridges, the teeth after being crowned may exhibit sensitivity. It may be mild to severe. This sensitivity may last for a short period of time or much longer periods. If it is persistent, notify us.

Crowned or bridge abutment teeth may require root canal treatment or implants subsequently: There is the possibility that the teeth after being filled, crowned or veneered may develop a condition known as pulpitis or pulpal degeneration. Usually, this cannot be predetermined. The tooth or teeth may have been traumatized from an accident, deep decay, extensive preparation, or other causes. In this case, it is often necessary to do a root canal treatment or extraction followed by implant of these teeth. Should teeth remain appreciably sensitive for a long period of time following filling, veneering, or crowning it may be necessary for additional treatment.

Breakage: Fillings, Veneers, Crowns and Bridges are subject to the possibility of chipping or breakage. There are many factors that may contribute to this including but not limited to biting, chewing and mastication of excessively hard materials, changes in the occlusal (biting) forces exerted, traumatic blows to the mouth, etc. Many times unobservable cracks may develop in crowns from the aforementioned causes, but may actually break when chewing soft foods, or possibly for no evident reason. Seldom does breakage or chipping occur due to defective construction materials. If this may be the reason, the breakage should occur soon after placement.

Uncomfortable or strange feeling: This may occur because of the differences between natural teeth and the artificial replacements. Normally, a patient will become accustomed to this feeling in time. If the feeling persists, notify us.

Aesthetic or appearance: Every attempt possible will be made to match and coordinate both the form and shade of veneers which will be place to be cosmetically pleasing to the patient. However, there are some differences which may exist between that which is natural and that which is artificial, making it impossible to have the shade and/or form perfectly match your natural dentition.

Longevity of fillings, crowns, veneers, bridges and implants: There are many variables that determine “how long” treatment can expect to last. Among these are some of the factors mentioned in preceding paragraphs. In addition, general health, maintenance of good oral hygiene, regular dental checkups, diet, oral habits etc., can affect longevity. Because of this, no guarantees can be made or assumed.

Injury to the nerves: Surgical procedures or local anesthesia may possibly result in injury to the nerves of the lips, tongue, or other oral tissues. Numbness could occur which may be either temporary or permanent.

Local Anesthesia: Numbness due to local anesthesia can last minutes to hours after a procedure is finished. Dr. Montgomery shall not be held liable for chipped teeth or patient biting cheeks, lips or tongue while still under local anesthesia.

It is the patient’s responsibility: To seek attention should any undue or unexpected problems occur and also to diligently follow any instructions, including scheduling and attending all appointments.

Informed Consent: I have been given the opportunity to ask any questions regarding the nature and purpose of treatment and have received answers to my satisfaction. I voluntarily assume any and all possible risks, including risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired results, which may or may not be achieved. No guarantees or promises have been made to me concerning the results. The fee(s) for this service(s) have been explained to me and are satisfactory. By signing this form, I am freely giving my consent to allow and authorize Dr. Montgomery and/or her associates to render any treatment they deem necessary, desirable and/or advisable to my dental conditions and oral health.

Signature of Patient, Parent or Guardian: ____ *Date:* _____________________

Safe Amalgam/Silver Filling Consent

At **Boise Caring Dentistry** we continually seek better and safer Dentistry. It is our protocol to safely remove amalgam or silver fillings for the health of our patients. Removal of toxic dental materials will cut off the supply of toxins, but that does nothing toward healing and repair. Balancing the body chemistry is required to supply the proper raw materials to bring about healing. It is important to follow the treatment plan set up by your primary healthcare provider before and after amalgam removal.

I,_______________________ read and understand that I am requesting Dr. Montgomery to remove silver fillings, as per my choice, even though there may or may not be defects, fractures or recurrent decay present and will not hold Dr. Montgomery liable for my overall health or lack thereof before or after dental treatment.

Ozone/Oxygen Therapy Consent

I, ____________________, do voluntarily, knowingly, and willingly give my consent to the administration of dental oxygen/ozone treatments. I seek this treatment at my own request.

I understand that the dental oxygen/ozone therapy is in the form of a gas with or without local anesthetic, into the skin, mucous membranes, muscles, joints, jawbones, and teeth of the head, neck and/or associated structures. Dental oxygen/ozone therapy is defined as the creation of a therapeutic oxygen rich environment, which induces a multi-factorial positive biochemical and physiologic change in the affected tissues. Dental oxygen/ozone therapy has the following dental relevant and useful properties: it kills bacteria, viruses, fungi and parasites. It is a circulatory stimulant, a wound-cleaner, an accelerant from wound healing a hemostatic agent, and an immune activation agent. There may be other effects that at this time are unknown.

I understand that I should tell the doctor or team members if I have ever had an allergic reaction to any anesthetic, particularly dental anesthetics prior to any treatment involving injections with anesthetics.

There are potential side effects with all types of dental treatments. Dental oxygen/ozone therapy carries with it some risk of side effects, such as: pain and/or discomfort at the injection site, soreness and temporary bruising. There may be a red, inflamed, blister-type area at the injections site. This usually heals in 1-5 day time period. All types of medications have some risk of allergic reactions. An allergic reaction to the mixture of oxygen/ozone would be unusual, and usually restricted to the injections site. The most common patient comment is that there is a warm to burning sensation at the site of the injection. Some patients may experience flu-like symptoms for 2 to 3 days following treatment.

Signature of Patient, Parent or Guardian: ____Date: _____________________

DATE OF HEALTH HISTORY UPDATE:

THIS IS A HEALTH HISTORY UPDATE. PLEASE INDICATE ANYTHING REGARDING YOUR HEALTH (MEDICAL AND DENTAL) THAT HAS CHANGED SINCE YOUR LAST VISIT TO OUR OFFICE. THANK YOU.

WHAT IS THE REASON FOR TODAY'S VISIT?	
DO YOU HAVE QUESTIONS OR CONCERNS?	
HAVE YOUR TEETH EMBARRASSED YOU IN THE LAST YEAR?	
DO YOU LOVE YOUR SMILE?	
IS THERE ANYTHING YOU WOULD LIKE TO CHANGE ABOUT YOUR SMILE?	
HAS YOUR HEALTH CHANGED DURING THE PAST SIX MONTHS?	
WHO MAY WE THANK FOR YOUR REFERRAL?	

1. PLEASE INDICATE ANY OF THE FOLLOWING YOU ARE NOW EXPERIENCING:

HEAD/FACE

- ☐ Forehead headaches
- ☐ Temporal headaches
- ☐ Tension headaches
- ☐ Migraine-type headaches
- ☐ Sinus headaches
- ☐ Back of head headaches
- ☐ Scalp tender to touch

NECK

- ☐ Lack of mobility
- ☐ Stiffness
- ☐ Neck pain
- ☐ Tired/sore neck muscles
- ☐ Shoulder pain
- ☐ Back pain
- ☐ Arm/finger pain or numbness

JAW

- ☐ Jaw pain
- ☐ Jaw joint pain
- ☐ Clicking/popping in jaw joint(s)
- ☐ Grinding sound in jaw joint(s)
- ☐ Pain in cheek muscles
- ☐ Uncontrollable jaw movements
- ☐ Jaw locks open/shut
- ☐ Deviation of jaw to one side

EARS

- ☐ Ear pain without infection
- ☐ Decreased hearing
- ☐ Clogged/stuffy feeling in ear(s)
- ☐ Itchy feeling in ear(s)
- ☐ Ringing/buzzing in ear(s)
- ☐ Dizziness
- ☐ Balance problems

EYES

- ☐ Pain in/around eyes
- ☐ Bloodshot eyes
- ☐ Sensitivity to light
- ☐ Tearing of eyes
- ☐ Blurred vision
- ☐ Pressure behind eyes
- ☐ Dark circles under eyes

MOUTH

- ☐ Abnormal opening Limited
- ☐ opening
- ☐ Bad bite
- ☐ Missing teeth
- ☐ Clenching/grinding teeth
- ☐ Mouth discomfort
- ☐ Inability to find bite
- ☐ Burning tongue
- ☐ Sour or foul taste in mouth

THROAT

- ☐ Difficulty swallowing
- ☐ Feeling of foreign object in throat
- ☐ Sore throat without infection
- ☐ Voice changes
- ☐ Laryngitis
- ☐ Frequent coughing or clearing

NASAL

- ☐ Sinus pain
- ☐ Sinus problems
- ☐ Post-nasal drainage
- ☐ Allergies

SLEEP

- ☐ Snoring
- ☐ Sleep apnea
- ☐ Have been told I snore
- ☐ Have been told I stop breathing
- ☐ Have awoken gasping for air

2. WHAT ARE THE CHIEF COMPLAINTS FOR WHICH YOU ARE SEEKING CARE? PLEASE ORDER COMPLAINTS BY NUMBER (1=MOST IMPORTANT, 10=LEAST)

	THROAT PAIN		BACK PAIN		PAIN BEHIND EYES		VISUAL DISTURBANCES
	JAW CLICKING		DIZZINESS		PAIN WHEN CHEWING		SINUS CONGESTION
	JAW JOINT NOISE		EAR PAIN		RINGING IN EARS		MUSCLE TWITCHING
	JAW LOCKING		FACIAL PAIN		SHOULDER PAIN		INABILITY TO OPEN MOUTH
	JAW PAIN		HEADACHES		LIMITED MOUTH OPENING		OTHER:
	NECK PAIN		FATIGUE		EAR CONGESTION		OTHER:

HAVE YOU TAKEN FOSAMAX, BONIVA, OR ANY OTHER BISPHOSPHONATE DRUG IN THE PAST ☐ Yes ☐ No

3. PLEASE LIST OTHER HEALTH PROVIDERS YOU ARE CURRENTLY SEEING.

	PRACTICIONER	SPECIALTY	TREATMENT RECEIVED	APRX DATE
1.				
2.				
3.				
4.				
5.				
6.				

4. THE EPWORTH SLEEPINESS SCALE

The Epworth Sleepiness Scale (ESS) was developed and validated by Dr. Murray Johns of Melbourne, Australia. It is a simple, self-administered questionnaire that is widely used by sleep professionals in quantifying the level of daytime sleepiness.

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling 'just tired'? This refers to your usual way of life at present and in the recent past. Even if you have not done some of these things recently, try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

SITUATION	CHANCE OF DOZING
Sitting and reading	______
Watching television	______
Sitting, inactive in a public place (e.g. theatre, meeting)	______
As a passenger in a car for an hour without a break	______
Lying down to rest in the afternoon when circumstances permit	______
Sitting and talking to someone	______
Sitting quietly after lunch without alcohol	______
In a car, while stopped for a few minutes in traffic	______

TOTAL SCORE ______

5. PLEASE INDICATE ANY MEDICATIONS/SUBSTANCES WHICH HAVE CAUSED AN ALLERGIC REACTION

☐ ANTIBIOTICS
☐ ASPIRIN
☐ BARBITURATES
☐ CODEINE
☐ IODINE
☐ LATEX
☐ LOCAL ANESTHETIC
☐ METALS
☐ PENICILLIN
☐ PLASTICS
☐ SEDATIVES
☐ SLEEPING PILLS
☐ SULFA DRUGS
OTHER ____________
OTHER ____________

6. PLEASE LIST ALL MEDICATIONS CURRENTLY BEING TAKEN

- ☐ ANTIBIOTICS
- ☐ ANTICOAGULANTS
- ☐ BARBITURATES
- ☐ BLOOD THINNERS
- ☐ CODEINE
- ☐ CORTISONE
- ☐ DIET PILLS
- ☐ HEART MEDICATION
- ☐ INSULIN
- ☐ MUSCLE RELAXANTS
- ☐ NERVE PILLS
- ☐ PAIN MEDICATION
- ☐ SLEEPING PILLS
- ☐ SULFA DRUGS
- ☐ TRANQUILIZERS

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

7. PLEASE UPDATE THE FOLLOWING MEDICAL/DENTAL HISTORY

	DETAILS
☐ ADENOIDS REMOVED?	
☐ TONSILS REMOVED?	
☐ ANEMIA	
☐ ARTERIOSCLEROSIS	
☐ ASTHMA	
☐ AUTOIMMUNE DISORDER	
☐ BLEEDING EASILY	
☐ HIGH BLOOD PRESSURE	
☐ LOW BLOOD PRESSURE	
☐ BRUISING EASILY	
☐ CANCER	
☐ CHEMOTHERAPY	
☐ CHRONIC FATIGUE	
☐ COLD HANDS/FEET	
☐ CURRENT PREGNANCY	
☐ DEPRESSION	
☐ DIABETES	
☐ DIFFICULTY FOCUSING	
☐ DIZZINESS	
☐ EMPHYSEMA	
☐ EPILEPSY	
☐ EXCESSIVE THIRST	
☐ FLUID RETENTION	
☐ FREQUENT COUGH	
☐ FREQUENT ILLNESS	

- [ ] FREQUENT STRESS
- [ ] GENERAL ANESTHESIA
- [ ] GLAUCOMA
- [ ] GOUT
- [ ] HAY FEVER

- [ ] HEARING IMPAIRMENT
- [ ] HEART MURMUR
- [ ] HEART DISORDER
- [ ] HEART PACEMAKER
- [ ] HEART PALPITATIONS
- [ ] HEART VALVE REPL.
- [ ] HEMOPHILIA
- [ ] HEPATITIS
- [ ] HYPOGLYCEMIA
- [ ] IMMUNE DISORDER
- [ ] INJURY TO FACE
- [ ] INJURY TO NECK
- [ ] INJURY TO MOUTH
- [ ] INJURY TO TEETH
- [ ] INSOMNIA
- [ ] INTESTINAL DISORDER
- [ ] JAW JOINT SURGERY
- [ ] KIDNEY PROBLEMS
- [ ] LIVER DISEASE
- [ ] MENIERE’S DISEASE
- [ ] MENSTRUAL CRAMPS
- [ ] MULTIPLE SCLEROSIS
- [ ] MUSCLE ACHES
- [ ] MUSCLE TREMORS
- [ ] MUSCLE CRAMPS
- [ ] MUSCULAR DYSTROPHY
- [ ] NEED PILLOW AT NIGHT
- [ ] NERVOUS IRRITABILITY
- [ ] NERVOUSNESS
- [ ] NEURALGIA
- [ ] OSTEOPOROSIS
- [ ] PARKINSON’S DISEASE
- [ ] POOR CIRCULATION
- [ ] PRIOR ORTHODONTICS
- [ ] PSYCHIATRIC CARE
- [ ] RADIATION TREATMENT
- [ ] RHEUMATIC FEVER
- [ ] RHEUMATOID ARTHRITIS
- [ ] SCARLET FEVER
- [ ] SHORTNESS OF BREATH
- [ ] SINUS PROBLEMS
- [ ] SKIN DISORDERS

☐ SLOW HEALING SORES
☐ SPEECH DIFFICULTY
☐ STROKE
☐ SWOLLEN JOINTS
☐ FREQUENT COLDS
☐ FREQ SORE THROAT

☐ FREQ EAR INFECTION
☐ TUBERCULOSIS
☐ TUBES IN EARS
☐ TUMORS
☐ URINARY DISORDERS
☐ 3RD MOLAR EXTRACTION
☐ FOSAMAX USE

I CERTIFY THAT THE ABOVE HISTORY IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNED NAME: X______________________________________

PRINTED NAME: ______________________________________