NorthStar Dental Health History

Dental Health History (Circle Yes or No)
Please complete to the best of your knowledge.

Do you want complete dental care? Y N
Are you apprehensive about dental treatment? Y N
Are you dissatisfied with the appearance of your teeth? Y N
Have you had problems with previous dental treatment? Y N
Do you gag easily? Y N
Do you have difficulty swallowing? Y N
Do you avoid brushing any part of your mouth because of pain? Y N
Do your gums bleed when you brush or floss? Y N
Does your mouth feel dry often? Y N
Have you noticed slow-healing sores in your mouth? Y N
Are your teeth sensitive Y N
- Hot foods or liquid? Y N
- Cold foods or liquid? Y N
- Sweets? Y N
- Biting? Y N

Does your jaw make noise that bothers you or others? Y N
Do you clench or grind your teeth frequently? Y N
Do you have any jaw soreness, or headaches upon awakening in the morning? Y N
Do you chew on only one side of your mouth? Y N
Do your gums feel swollen or tender? Y N
Does food get stuck in one area? Y N
Do you experience ringing in the ears? Y N

Medical Health History
(Do you have, or have you had, any of the following?)

AIDS/HIV Y N
Anemia Y N
Arthritis, Rheumatoid Y N
Artificial Heart Valves Y N
Artificial Joints Y N
Location_____
Joint Reinfections Y N

Medical Health History (Cont.)
Asthma Y N
Back Problems Y N
Bleeding Problems/Easy Bruising Y N
Blood Disease Y N
Cancer, Type_____ Y N
Chemical/Alcohol Dependency Y N
Chemotherapy Y N
Circulatory Problems Y N
Congenital Heart Problems Y N
Cortisone Treatments Y N
Cough, persistent or bloody Y N
Depression/Anxiety Y N
Diabetes, Type I or II Y N
Emphysema Y N
Epilepsy / Siezures Y N
Fainting/Dizziness Y N
Glaucoma Y N
Head injury Y N
Heartburn Y N
Heart Problems Y N
Hepatitis, type_____ Y N
Herpes or other STD Y N
Heart Murmur Y N
High blood pressure Y N
Jaundice Y N
Kidney Disease Y N
Liver Disease Y N
Low Blood Pressure Y N
Lupus Y N
Mitral Valve Prolapse Y N
Pacemaker Y N
Psychiatric Care Y N
Radiation Treatment Y N
Respiratory Disease Y N
Rheumatic Fever Y N
Scarlet Fever Y N
Scleroderma Y N
Shortness of Breath Y N
Sinus Trouble Y N
Skin Rash Y N
Special Diet Y N
Stroke (When)_____ Y N
Swollen Feet or Ankle Y N
Swollen Neck Glands Y N
Sjogren's Y N
Thyroid Problems Y N
Tonsillitis Y N
Tuberculosis Y N
Tumor or growth on head/neck Y N
Ulcer Y N
Weight loss, unexplained Y N

Airway Health
Do you feel excessively tired throughout the day? Y N
Do you wish you slept better and had more energy? Y N
Have you ever been told you occasionally snore? Y N
Have you or a loved one been prescribed a C-PAP? Y N
Have you had a sleep study? Y N

Women:
Are you pregnant? Y N
Expected delivery date _____
Taking contraceptives or other hormones? Y N

Medications Allergies
Aspirin Y N
Codeine Y N
Ibuprofen Y N
Latex Y N
Local anesthetics Y N
Metals Y N
Penicillin/Amoxicillin Y N
Sulfa Y N
Tylenol Y N
Other_____

Medications (list all currently taking)

_____

_____

_____

_____

_____

_____

Other Condition or Disease not listed:

_____

_____

_____

Consent: I hereby agree to allow Dr. Ronngren and associates to perform any necessary, agreed upon dental services. I also allow all them to delegate to the auxiliaries of their choice as needed to accomplish my treatment. I understand that there is an inherent risk with any dental procedure, including dental anesthesia. I hereby allow them to take any necessary x-rays, study models or photographs as needed for my dental care. I understand that the entire fee is my responsibility and that NorthStar Dental will submit to my dental insurance as a courtesy. I agree to be responsible for any collection fees necessary to pursue a past debt.

Patient Signature: _____ Date: _____ Provider Signature: _____ Date: _____