

M. Todd Bonin, D.D.S. _____

Dental History: Date ___/___/_____

Former Dentist: _____ Date of last dental x-rays: _____

Reason for today's visit: _____

How often do you brush? _____ Floss? _____

Circle ALL That Apply:

Bad Breath Loose Teeth Popping Jaws Sensitivity To Heat/Cold Grinding Teeth Sensitivity To
Sweets Loose Fillings Periodontal Treatment Bleeding Gums Pain When Biting Fractured Teeth
Growth in Mouth Denture/Partial Doesn't Fit Swelling In Mouth Infection Broken Fillings Pain
Dry Mouth Snoring Bite Problems Don't like My Smile

Medical History: Date / /

Medications: (1) _____ (2) _____ (3) _____
(4) _____ (5) _____ (6) _____

Drug Allergies: _____

Circle ALL That Apply:

Anemia Blood Thinners Heart Surgery Bleeding Problems Blood Clots Heart Murmurs
Blood Disease Circulatory Problems Stokes(s) High Blood Pressure Heart Attacks Hemophilia
Heart Failure Artificial Heart Valves Breathing Problems Asthma COPD Emphysema
Smoker Shortness of Breath Cough Tuberculosis Cancer Osteoporosis
IV Bi-Phosphonates Heart Burn Reflux Disease Frequent Urination Frequent Thirst Diabetes
Liver Problems Hepatitis Digestive Problems Artificial Joints Back Problems Painful Joints
Kidney/Urinary Problems Thyroid Problems Psychiatric Problems Chemical Dependency
Seizures/Epilepsy HIV/AIDS

Have you been hospitalized in the past 5 years? Yes / No Reason: _____

WOMEN: Are you Pregnant? Yes / No Birth Control Pills? Yes / No Nursing? Yes / No

I certify I have read and understand the above questions. I have answered all questions accurately. I authorize Dr. Bonin and his Staff to release any information including diagnosis and the records of any treatment or examinations rendered to me or my child during the period of such dental care to third party payers and/or health practitioners or emergency personnel.

SIGNATURE

DATE

