P: 541-756-7568
F: 541-756-0760

ABOVE DENTAL

2070 Virginia Avenue
North Bend, OR 97459
abovedental.com

PATIENT'S HISTORY

Name: _____ Birth Date: _____ Today's Date: _____

DENTAL HISTORY

Reason for Today's Visit: _____ Date of Last Dental Care: _____

Former Dentist: _____ Reason for Leaving: _____

Circle if you have been experiencing any of the Following:

Bad Breath Grinding Teeth Sensitivity to Heat Bleeding Gums Loose Teeth Broken Teeth

Sensitivity to Sweets Clicking or Popping Jaw Sensitivity to Biting Food Collection between Teeth

Sensitivity to Cold Sores or Growths in your Mouth Other: _____

Our Office offers many Services, Please circle any you may be interested in::

Sedation (IV, Oral or laughing gas) Replacement of Missing Teeth Wisdom Teeth Removal

Whiter Teeth Veneers or Lumineers Tooth Colored Fillings Repair of Broken Teeth

Dentures Denture Repair Tighter Dentures Dental Implants

Do you now OR have you ever had any of the following? Please circle "Y" for Yes or "N" for No.

Anemia	Y N		Hepatitis	Y N	
Arthritis or Rheumatism	Y N		Hernia Repair	Y N	
Artificial Heart Valves	Y N		High Blood Pressure	Y N	
Artificial Joints, Pins, etc.	Y N		HIV/AIDS	Y N	
Asthma	Y N		Jaw Pain	Y N	
Back Problems	Y N		Kidney Disease	Y N	
Bisphosphonates for Osteoporosis (e.g. Fosamax)	Y N		Liver Disease	Y N	
Bleeding Abnormalities	Y N		Mitral Valve Prolapse	Y N	
Blood Disease	Y N		Pacemaker	Y N	
Cancer	Y N		Radiation Treatment	Y N	
Chemical Dependency	Y N		Respiratory Disease	Y N	
Chemotherapy	Y N		Rheumatic Fever	Y N	
Circulatory Problems	Y N		Scarlet Fever	Y N	
Congenital Heart Lesions	Y N		Shortness of Breath	Y N	
Cortisone Treatments	Y N		Skin Rash	Y N	
Persistent Cough	Y N		Stroke	Y N	
Cough up Blood	Y N		Swelling of Feet or Ankles	Y N	
Diabetes	Y N		Thyroid Problems	Y N	
Epilepsy	Y N		Tobacco Habit	Y N	
Fainting	Y N		Tonsillitis	Y N	
Headaches	Y N		Tuberculosis	Y N	
Heart Murmur	Y N		Ulcer	Y N	
Heart Problems	Y N		Venereal Disease	Y N	
Hemophilia	Y N		Other: _____	Y N	

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MEDICAL HISTORY

Physician's Name: _____ Date and Reason for Last Visit: _____

_____

Have you had any serious Illness or Surgery in the last two Years: ☐ NO ☐ YES, Please explain: _____

_____

Woman: Are you Pregnant? ☐ NO ☐ YES, Due Date: _____ Nursing? ☐ NO ☐ YES

Please list all medications you take, including over-the-counter and herbal medicines and their correlating diagnosis:

_____

_____

_____

_____

_____

_____

Do you have any Allergies: ☐ NO ☐ YES, Please list: _____

_____

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative | Date

_____ _____

Signature of Patient, Parent, Guardian, or Personal Representative | Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.