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.

Condition	Y/N		Condition	Y/N	
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	______

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

ABOVE DENTAL

2070 Virginia Avenue
North Bend, OR 97459
abovedental.com

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.