Allergies

[ ] ACRYLIC [ ] ASPIRIN [ ] CODEINE [ ] DENTAL ANESTHETICS

[ ] ERYTHROMYCIN [ ] LATEX [ ] METAL [ ] PENICILLIN [ ] TETRACYCLINE

Please list any other drugs that you might be allergic to: ______________________________

DENTAL HISTORY

Why have you come to the dentist today?

Are you currently in pain? [ ] Yes [ ] No Do your gums ever bleed? [ ] Yes [ ] No

Have you had a serious/difficult problem associated with previous dental work? [ ] Yes [ ] No

If yes, explain: ____

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Do you like your smile? [ ] Yes [ ] No If no, what would you change? ____________________

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*How many times a day do you floss?*______________ *a day do you brush?*______________

Type of bristles on your toothbrush? {] Soft [ ] Medium [ ] Hard [ ] Electric toothbrush (what type: ________________________ *)*

Authorizations

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment. Payment is due in full at the time of treatment unless prior arrangements have been approved.

Thank you for filling this form out completely. It will enable our office to assist you more effectively. If you have questions at any time, please ask us. We are happy to help!!

Signed: ________________________ *Date:* __________________

C.R. Edwards, Jr. D.D.S.

2509 Park Drive Sanford, FL 32773

Ph: (407) 322-6052 Fax: (407) 322-6059