Green Hills
DENTAL GROUP
John L. Farringer III, D.D.S.

Name:____
Reason for Today's Visit: ____
Date of last dental visit: _________________
Former Dentist: _______________________ Phone #____________________
Physician's Name: ______________________ Phone #____________________
Have you ever been instructed by any doctor to premedicate before dental visits? □ yes □ no
How often do you floss? ________________________ How often do you brush? ________________________

Allergies: □ Aspirin □ Barbiturates (sleeping pills) □ Codeine □ Iodine □ Latex □ Sulfa
□ Local Anesthetic □ Penicillin □ Other________________________________
Medications: ____
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Pharmacy Name____________________________ **Pharmacy #**______________________

DENTAL/HEALTH HISTORY

Check if you have had any of the following:

- □ AIDS/HIV
- □ Anemia
- □ Arthritis, Rheumatism
- □ Artificial joints or heart valves
- □ Asthma
- □ Back problems
- □ Bad breath
- □ Bleeding abnormally after extractions
- □ Bleeding gums
- □ Blisters on lips or mouth
- □ Blood disease
- □ Burning sensation on tongue
- □ Cancer
- □ Chemical dependancy
- □ Chemotherapy
- □ Chew on one side of mouth
- □ Cigarette, pipe or cigar smoking
- □ Circulatory problems
- □ Clicking or popping of jaw
- □ Congenital heart lesions
- □ Cortisone treatments
- □ Cough, persistent or bloody
- □ Diabetes
- □ Dry mouth
- □ Emphysema
- □ Epilepsy
- □ Fainting or Dizziness
- □ Fingernail biting
- □ Food collection between teeth
- □ Foreigh objects in mouth
- □ Glaucoma
- □ Grinding teeth
- □ Growth or tumor on head or neck
- □ Headaches
- □ Heart murmur
- □ Heart problems
- □ Hepatitis Type_______
- □ Herpes
- □ High Blood Pressure
- □ Jaundice
- □ Kidney disease
- □ Lip or cheek biting
- □ Liver disease
- □ Loose teeth or broken fillings
- □ Low blood pressure
- □ Mitral valve prolapse
- □ Mouth breathing
- □ Mouth pain, brushing
- □ Nervous problems
- □ Orthdontic treatment
- □ Pace maker
- □ Pain around ear
- □ Periodontal treatment
- □ Psychiatric care
- □ Radiation treatment
- □ Respiratory disease
- □ Rheumatic fever
- □ Scarlet fever
- □ Sensitivity to cold
- □ Sensitivity to heat
- □ Sensitivity to sweets
- □ Shortness of breath
- □ Sinus trouble
- □ Skin rash
- □ Sores or growth in mouth
- □ Special diet
- □ Stroke
- □ Swollen feet or ankles
- □ Swollen neck glands
- □ Thyroid problems
- □ Tonsillitis
- □ Tuberculosis
- □ Ulcer
- □ Venereal Disease

WOMEN:

Are you pregnant? □ yes □ no
Are you nursing? □ yes □ no
Birth control pills? □ yes □ no