

Dental History

Why have you come to the dentist today? _____

Are you currently in pain? Yes No

Do you require antibiotics before dental treatment? Yes No

Your current dental health is Good Fair Poor

Do you floss daily? Yes No Brush Daily? Yes No

Type of toothbrush you use? Manual Electric

Are you satisfied with the appearance of your teeth? Yes No

If no, what would you like to change? (circle those that apply)

Length, Shade, Spaces, Crowding, Other: _____

Have you ever had any head, neck, or jaw injuries? Yes No

Do you have frequent headaches? Yes No

Do your gums ever bleed? Yes No

Have you ever had periodontal disease? Yes No

Are your teeth sensitive to heat, cold, or anything else? _____

Do you have any loose teeth? Yes No

Previous / Present Dentist: _____ Last visit date: _____

Have you ever experienced any of the following problems in your jaw?

Clicking Yes No

Pain (joint, ear, side of face)? Yes No

Difficulty in opening or closing? Yes No

Difficulty in chewing? Yes No

Do you clench or grind your teeth? Yes No

Have you had any orthodontic work? Yes No

Have you ever whitened your teeth? Yes No

If yes, what type of product? _____

Have you ever been told you are difficult to numb? Yes No

Medical History

Do you have a personal physician? Yes No

Physician's Name: _____

Phone #: _____ Date of last visit: _____

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No

Please explain: _____

Do you smoke or use tobacco in any other form? Yes No

Have you ever taken Phen-Fen, Redux or Pondimin? Yes No

For Women: Are you taking birth control pills? Yes No

Are you pregnant? Unsure Yes No

Week #: _____

Are you nursing? Yes No

Do you or have you experienced the following?

Y N Abnormal Bleeding	Y N Diabetes	Y N Headaches	Y N Lupus	Y N Steroid Therapy
Y N Alcohol Abuse	Y N Difficulty Breathing	Y N Heart Attack	Y N Mitral Valve Prolapse	Y N Stroke
Y N Artificial Bones/Joints	Y N Drug Abuse	Y N Heart Murmur	Y N Pacemaker	Y N Thyroid Problems
Y N Artificial Valves	Y N Emphysema	Y N Heart Surgery	Y N Psychiatric Care	Y N Tonsillitis
Y N Asthma	Y N Epilepsy	Y N Hepatitis	Y N Radiation Treatment	Y N Tuberculosis (TB)
Y N Cancer	Y N Ever Hospitalized	Y N High Blood Pressure	Y N Rheumatic Fever	Y N Ulcers
Y N Chemotherapy	Y N Fainting Spells	Y N HIV+/AIDS	Y N Seizures	
Y N Congenital Heart Defect	Y N Fever Blisters	Y N Low Blood Pressure	Y N Sinus Problems	

Please list any serious medical condition(s) that you have experienced: _____

Are you taking any prescriptions/over the counter drugs, blood thinners or heart medications? Yes No If yes, please list each one: _____

Are you allergic to any of the following?

Y N Aspirin	Y N Codeine	Y N Erythromycin	Y N Latex	Y N Sedatives	Y N Tetracycline
Y N Barbiturates	Y N Dental Anesthetics	Y N Jewelry / Metals	Y N Penicillin	Y N Sulfa Drugs	Y N Other

Please list anything additional that causes allergic reactions: _____

Authorizations

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I understand that I am responsible for payment of services rendered.

Signature

Date