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 bristles on your toothbrush? ❑ Hard ❑ Medium ❑ Soft

Do your gums ever bleed? ❑ Yes ❑ No Ever Itch? ❑ Yes ❑ No

Have you ever had periodontal disease? ❑ Yes ❑ No

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

Do you have mobility in your teeth? ❑ Yes ❑ No

Do you still have wisdom teeth? ❑ Yes ❑ No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ❑ Yes ❑ No

Previous / Present Dentist: _____ (Please Circle) Last Visit Date: _____

Would you like fresher breath? ❑ Yes ❑ No Whiter teeth? ❑ Yes ❑ No

Are you happy with the way your smile looks? ❑ Yes ❑ No

If not, what would you change? _____

_____

Medical History

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name: _____

Address: _____
Street

_____
City State Zip

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

Do you snore? ❑ Yes ❑ No

Do you have difficulty falling or staying asleep? ❑ Yes ❑ No

When you awaken in the morning, do you feel rested? ❑ Yes ❑ No

Are you tired/sleepy during the day? ❑ Yes ❑ No

Have you ever taken Fosamax or any other Bisphosphonate? ❑ 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 Colitis	Y N Hay Fever	Y N Liver Disease	Y N Seizures
Y N Alcohol Abuse	Y N Congenital Heart Defect	Y N Headaches	Y N Low Blood Pressure	Y N Shingles
Y N Anemia	Y N Diabetes	Y N Heart Attack	Y N Lupus	Y N Sickle Cell Disease
Y N Arthritis	Y N Difficulty Breathing	Y N Heart Murmur	Y N Mitral Valve Prolapse	Y N Sinus Problems
Y N Artificial Bones/Joints	Y N Drug Abuse	Y N Heart Surgery	Y N Osteoporosis	Y N Steroid Therapy
Y N Artificial Valves	Y N Emphysema	Y N Hemophilia	Y N Pacemaker	Y N Stroke
Y N Asthma	Y N Epilepsy	Y N Hepatitis	Y N Persistent Cough	Y N Thyroid Problems
Y N Blood Transfusion	Y N Ever Hospitalized	Y N Herpes	Y N Psychiatric Problems	Y N Tonsillitis
Y N Cancer	Y N Fainting Spells	Y N High Blood Pressure	Y N Radiation Treatment	Y N Tuberculosis (TB)
Y N Chemotherapy	Y N Fever Blisters	Y N HIV+/AIDS	Y N Rheumatic Fever	Y N Ulcers
Y N Chicken Pox	Y N Glaucoma	Y N Kidney Problems	Y N Scarlet Fever	Y N Venereal Disease

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

Are you taking any prescription/over the counter drugs? ❑ 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: _____

_____

Authorization

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 assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover. I have received a copy of this offices Notice of Privacy Practices.

_____
Signature Date