DENTAL HISTORY

Please check any of the following problems that apply to you:

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Tooth pain or discomfort when chewing
- ☐ Headaches, ear aches, neck pain
- ☐ Mouth ulcers or cold sores
- ☐ Jaw joint pain
- ☐ Broken tooth or fillings
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, tipped or shifted teeth
- ☐ Bad breath or bad taste in your mouth

Do you have or have you had any of the following?

- ☐ Dentures
- ☐ Braces
- ☐ Gum treatments
- ☐ **Required to take antibiotics prior to dental treatment**

Please share the following dates:

Your last cleaning:_____/_____

Your last complete x-rays:_____/_____

Name of Previous Dentist:

_____

City:_____State:_____

Phone number: _____

Why did you leave your previous dentist?

_____

What is the most important thing to you about your future Smile and dental health?_____

_____

Do you smoke or use chewing tobacco? How much? For How long?

_____

If you could change your smile, you would:

- ☐ Make my teeth whiter
- ☐ Make my teeth straighter
- ☐ Close spaces
- ☐ Replace metal fillings with tooth colored fillings
- ☐ Repair chipped teeth
- ☐ Replace missing teeth
- ☐ Replace old crown that don't match
- ☐ Have a smile makeover
- ☐ Implants

On a scale of 1-10, with 10 being the highest rating:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

What is the most important thing to you about your dental visit Today?

_____

_____

MEDICAL HISTORY

Please check any of the following that apply to you:

- ☐ Allergies (Seasonal)
- ☐ Anemia
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ Marijuana Use
- ☐ Recreational Drug Use
- ☐ Excessive Bleeding
- ☐ Glaucoma
- ☐ Heart Conditions
- ☐ Heart Murmur
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Nervousness
- ☐ Depression
- ☐ Pacemaker
- ☐ Phen Fen (1 month +)
- ☐ Radiation (head/neck)
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Thyroid Disease
- ☐ Mitral Valve Prolapse
- ☐ Emphysema
- ☐ Ulcers
- ☐ Pregnant
- ☐ Have you ever taken Bisphosphonates? (i.e. Aredia, Fosamax, Boniva)
- ☐ other:

_____

Do you have an allergy to any of the following?

- ☐ Aspirin
- ☐ Erythromycin
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Nitrous Oxide
- ☐ Penicillin
- ☐ Codeine

Other:_____

What surgeries have you had?

_____

_____

_____

_____

_____

_____

_____

_____

What medications/supplements/over the counter medications are you taking? _____

_____

_____

_____

Family Physician **Phone Number**

_____

Are you under a physician's care? For what?

_____

Have you ever been a victim of abuse and neglect? ☐ **Yes** ☐ **No**

Are you currently a victim of abuse and neglect? ☐ **Yes** ☐ **No**

Patient Signature (or parent of child)	**Date**	**Doctor's Signature**