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
- Obstructive Sleep Apnea
- 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**