

Patient Name _____ Birth Date _____

Dental History

What would you like us to do today? _____ Are you in discomfort? _____

Former Dentist _____ Address _____ Phone _____

Date of last X-RAYS _____ Date of last dental care _____

Please circle Yes or No if you have any of the following

- | | | | |
|---------------------------|---------------------------------|---------------------------------|-----------------------------------|
| Y N Bad breath | Y N Sensitivity to hot or cold | Y N Clicking/Popping of the Jaw | Y N Food Collection between teeth |
| Y N Bleeding Gums | Y N Sensitivity when biting | Y N Headaches or jaw/joint pain | Y N Sores in mouth |
| Y N Periodontal Treatment | Y N Loose teeth/broken fillings | Y N Grinding the teeth | Y N Dry mouth |

Please describe current dental problems _____

How often do you brush? _____ Floss? _____ Do you smoke? Y N How much per day? _____

How do you feel about the appearance of your teeth? _____ Are you interested in whitening? _____

Have you ever had an adverse reaction to any dental procedure or any bad experience? _____

Medical History

Physician's Name _____ Address _____

Phone _____ Email _____ Date of last visit _____

Have you had any serious illness or operations? Y N If yes, describe _____

Are you currently under physicians care? Y N If yes, describe _____

Are you currently taking blood thinners (including Warfarin or Aspirin)? Please List _____

Are you on or have you ever taken medication for Bone Metabolism/Osteoporosis (Including Fosamax, Boniva or Actonel)?
Please list _____

Are you allergic to any of the following?

Penicillin	Latex	Aspirin	Codeine	Acrylic	Metal	Local Anesthetics	Other
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Please list any other allergies _____

Women: Are you pregnant? Y N Nursing? Y N Taking birth control pills? Y N

Circle if you have had or currently have any of the following:

- | | | | |
|---------------------------|------------------------|------------------------|--------------------------------|
| Y N AIDS or HIV | Y N Hemophilia | Y N Surgical Implants | Y N Heart Problems |
| Y N Alcohol /Drug Abuse | Y N Excessive Bleeding | Y N Thyroid Disease | Y N Congenital Heart Disorder |
| Y N Artificial Joints | Y N Heredity Problems | Y N Tuberculosis | Y N Infective Endocarditis |
| Y N Asthma | Y N Herpes/Cold Sores | Y N Coughing up blood | Y N Prosthetic Cardiac valve |
| Y N Blood Disease | Y N Hepatitis | Y N Heart Murmur | Y N Stomach/Intestinal Disease |
| Y N Cancer, Chemo Therapy | Y N Kidney Disease | Y N Ulcerative Colitis | Y N Mitral Valve Prolapse |
| Y N Radiation Treatment | Y N Liver Disease | Y N Acid Reflux | Y N Pace Maker/ Heart Surgery |
| Y N Cortisone Treatment | Y N Glaucoma | Y N Venereal Disease | Y N Heart Attack |
| Y N Diabetes | Y N Psychiatric Care | Y N Sinus Trouble | Y N Angina/Chest Pain |
| Y N Fainting | Y N Seizures/ Epilepsy | Y N Immunosuppression | Y N Lung/Respiratory Disease |
| Y N Stroke | Y N Osteoporosis | Y N Sleep Apnea | Y N Other _____ |

Please list all medications you are currently taking: 1. _____ 2. _____

3. _____ 4. _____ 5. _____ 6. _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in my medical status

Signature of Patient, parent, or Guardian _____ **Date** _____