DENTAL HISTORY

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

- -Sensitivity (hot, cold, sweet) ☐
  - Where? UR LR LR UL LL
- -Headaches, earaches, neck pain ☐
- -Jaw joint pain ☐
- -Teeth or fillings breaking ☐
- -Grinding or clenching teeth ☐
- -Bleeding, swollen or irritated gums ☐
- -Loose, tipped, or shifting teeth ☐
- -Bad breath ☐

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

- -Dentures ☐
- -Partial dentures ☐
- -Braces ☐
- -Periodontal (gum) treatments ☐

Please share the following dates:

- -Your last cleaning ___ / ___
- -Your last oral cancer screening ___ / ___
- -Your last complete X-Rays ___ / ___

Name of Previous Dentist ______________________

City ______________ State ______________

Phone Number ______________________

What is the most important thing to you about your future smile and dental health? ______________________

	Y	N
If you could whiten your teeth for a cost anyone could afford, would you do it?	☐	☐
Do you smoke or use chewing tobacco?	☐	☐

How much? For how long?

If I could change my smile, I would:

- -Make them whiter ☐
- -Make them straighter ☐
- -Close Spaces ☐
- -Replace black metal fillings with tooth colored restorations ☐
- -Repair chipped teeth ☐
- -Replace missing teeth ☐
- -Replace old crowns that don't match ☐
- -Have a smile makeover ☐

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
- -Where do you want your dental health to be?
  1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?

____

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:

AIDS	☐	Drug Addiction	☐	HIV Positive	☐	Rheumatic Fever	☐
Allergies (Seasonal)	☐	Emphysema	☐	Jaundice	☐	Rheumatism	☐
Anemia	☐	Excessive Bleeding	☐	Jaw Joint Pain	☐	Scarlet Fever	☐
Arthritis	☐	Fainting	☐	Kidney Disease	☐	Seizures	☐
Artificial Heart Valve	☐	Glaucoma	☐	Liver Disease	☐	Stomach Problems	☐
Artificial Joints	☐	Heart Conditions	☐	Low Blood Pressure	☐	Stroke	☐
Asthma	☐	Heart Lesions (Congenital)	☐	Mitral Valve Prolapse	☐	Thyroid Disease	☐
Blood Disease	☐	Heart Murmur	☐	Nervousness/Depression	☐	Tuberculosis	☐
Bruise Easily	☐	Heart Surgery	☐	Pacemaker	☐	Ulcers	☐
Cancer	☐	Hepatitis A	☐	Phen Fen (1 month +)	☐	Venereal Diseases	☐
Chemotherapy	☐	Hepatitis B	☐	Pregnant Currently	☐	Other	☐
Diabetes	☐	Hepatitis C	☐	Radiation (head/neck)	☐		
Dizziness	☐	High Blood Pressure	☐	Respiratory Problems	☐		

Do you have any of the following drug allergies?

Aspirin	☐	Codeine	☐	Other	☐
Darvon	☐	Erythromycin	☐		
Nitrous Oxide	☐	Valium	☐		
Percodan	☐	Penicillin	☐		
Local Anesthetic	☐	Sulfa	☐		

Are you under a physician's care? What for?

____

Are you taking any medications? What?

____

Family Physician ______________ Phone Number ______________

Patient Signature (Parent if Child) ______________________ Date ______________ Dentist Signature ______________________