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? ☐Good ☐Fair ☐Poor

Do you floss daily? ☐Yes ☐No Brush daily? ☐Yes ☐No

Type of bristles in your toothbrush? ☐Hard ☐Med ☐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

Previous Dentist _____ Last visit _____

Would you like fresher breath? ☐Yes ☐No

Would you like 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:	City:	State:	Zip:
Phone:	Date of last visit:		
Your current physical health? ☐Good ☐Fair ☐Poor			
Do you smoke or use tobacco in any form? ☐Yes ☐No			

Are you currently under the care of a physician? ☐Yes ☐No

Please explain:_____

Have you ever taken Phen-Fen, Redux or Pandimin? ☐Yes ☐No

For women: Are you taking birth control? ☐Yes ☐No

Are you pregnant? ☐Unsure ☐Yes ☐No

Week#_____ Are you nursing? ☐Yes ☐No

Do you or have you experienced the following? (check all that apply)

❑ Abnormal bleeding	❑ Colitis	❑ Hay Fever	❑ Liver disease	❑ Shingles
❑ Alcohol abuse	❑ Congenital heart	❑ Headaches	❑ Low blood pressure	❑ Sickle Cell Disease
❑ Anemia	❑ Diabetes	❑ Heart attack	❑ Lupus	❑ Sinus problems
❑ Arthritis	❑ Difficulty breathing	❑ Heart murmur	❑ Mitral valve prolapse	❑ Steroid Therapy
❑ Artificial bones/joints	❑ Drug abuse	❑ Heart surgery	❑ Pacemaker	❑ Stroke
❑ Artificial valves	❑ Emphysema	❑ Hemophilia	❑ Persistent cough	❑ Thyroid problems
❑ Asthma	❑ Epilepsy	❑ Hepatitis	❑ Psychiatric problems	❑ Tonsillitis
❑ Blood transfusion	❑ Ever hospitalized	❑ Herpes	❑ Radiation treatment	❑ Tuberculosis (TB)
❑ Cancer	❑ Fainting spells	❑ High blood pressure	❑ Rheumatic Fever	❑ Ulcers
❑ Chemotherapy	❑ Fever blisters	❑ HIV+/AIDS	❑ Scarlet Fever	❑ Venereal Disease
❑ Chicken Pox	❑ Glaucoma	❑ Kidney problems	❑ Seizures	

Please list any serious medical conditions that you have experienced:

Do you take any prescription/over the counter drugs? ☐Yes ☐No Please list:

Are you allergic to any of the following? (check all that apply)

☐ Aspirin	☐ Codeine	☐ Erythromycin	☐ Latex	☐ Sedatives	☐ Tetracycline
☐ Barbiturates	☐ Dental anesthetics	☐ Jewelry/metals	☐ Penicillin	☐ Sulfa drugs	☐ 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.

Print full name:_____ **Signature:**_____ **Date:**_____

Reviewed by: _____ **Date:**_____