

Patient Name _____

DENTAL HISTORY

Reason for dental visit today _____

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

	Yes	No
-Sensitivity (hot; cold, sweet, pressure) Where? UR LR UL LL	<input type="checkbox"/>	<input type="checkbox"/>
-Headaches, earaches, neck pain	<input type="checkbox"/>	<input type="checkbox"/>
-Jaw joint pain	<input type="checkbox"/>	<input type="checkbox"/>
-Teeth or fillings breaking	<input type="checkbox"/>	<input type="checkbox"/>
-Grinding or clenching teeth	<input type="checkbox"/>	<input type="checkbox"/>
-Gums bleed while brushing & Flossing	<input type="checkbox"/>	<input type="checkbox"/>
-Loose, tipped or shifting teeth	<input type="checkbox"/>	<input type="checkbox"/>
-Bad breath	<input type="checkbox"/>	<input type="checkbox"/>
-Do you grind your teeth	<input type="checkbox"/>	<input type="checkbox"/>
Do you have or have you had any of the following?		
-Dentures	<input type="checkbox"/>	<input type="checkbox"/>
-Partial dentures	<input type="checkbox"/>	<input type="checkbox"/>
-Braces	<input type="checkbox"/>	<input type="checkbox"/>
-Periodontal (gum) treatments	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
If you could whiten your teeth for a cost anyone could afford, would you do it?	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke or use chewing tobacco?	<input type="checkbox"/>	<input type="checkbox"/>
How much? _____ For how long? _____		
If I could change my smile, I would:		
-Make it whiter	<input type="checkbox"/>	<input type="checkbox"/>
-Make it straighter	<input type="checkbox"/>	<input type="checkbox"/>
-Close spaces	<input type="checkbox"/>	<input type="checkbox"/>
-Replace black metal fillings with tooth colored restorations	<input type="checkbox"/>	<input type="checkbox"/>
-Repair chipped teeth	<input type="checkbox"/>	<input type="checkbox"/>
-Replace missing teeth	<input type="checkbox"/>	<input type="checkbox"/>
-Replace old crowns that don't match	<input type="checkbox"/>	<input type="checkbox"/>
-Have a smile makeover	<input type="checkbox"/>	<input type="checkbox"/>

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

How do you feel about 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? _____

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 _____

MEDICAL HISTORY

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

	YES	NO		YES	NO		YES	NO		YES	NO
AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Allergies (Seasonal)	<input type="checkbox"/>	<input type="checkbox"/>	Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	HPV (Human Papilloma Virus)	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Angina (Chest pain)	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Jaw Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Problems	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Conditions	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Lesions (Congenital)	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness/Depression	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Diseases	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant Currently	<input type="checkbox"/>	<input type="checkbox"/>	Other _____		
Cervical Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	Radiation (head/neck)	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Cortisone Medication	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	_____		

Are you allergic or have you reacted adversely to any of the following medications?

	YES	NO		YES	NO		YES	NO		YES	NO
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>	Percodan	<input type="checkbox"/>	<input type="checkbox"/>	Tetracycline	<input type="checkbox"/>	<input type="checkbox"/>	Valium	<input type="checkbox"/>	<input type="checkbox"/>
Darvon	<input type="checkbox"/>	<input type="checkbox"/>	Latex	<input type="checkbox"/>	<input type="checkbox"/>	Codeine	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
Nitrous Oxide	<input type="checkbox"/>	<input type="checkbox"/>	Local Anesthetic	<input type="checkbox"/>	<input type="checkbox"/>	Erythromycin	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa	<input type="checkbox"/>	<input type="checkbox"/>

Other _____

Have you had an orthopedic total joint (hip, knee, elbow, finger replacement)? YES NO Date _____

Have you ever taken any the following medications?

	YES	NO		YES	NO
Actonel	<input type="checkbox"/>	<input type="checkbox"/>	Zometa	<input type="checkbox"/>	<input type="checkbox"/>
Aredia	<input type="checkbox"/>	<input type="checkbox"/>	Boniva	<input type="checkbox"/>	<input type="checkbox"/>
Fosamax	<input type="checkbox"/>	<input type="checkbox"/>	Herbal	<input type="checkbox"/>	<input type="checkbox"/>
Reclast	<input type="checkbox"/>	<input type="checkbox"/>	Supplements		

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

What medications are you currently taking? _____

Family Physician _____ Phone Number _____

Date of last physical exam _____

Consent:

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.

Patient Signature (Parent if child) _____

Date _____

Dentist Signature _____