NAME:

DENTAL HISTORY

	Yes	No
Please check any of the following that apply:		
-Sensitivity (hot, cold, sweet) Where? UR LR UL LL	☐	☐
-Headaches, earaches, neck pain	☐	☐
-Jaw joint pain	☐	☐
-Teeth or fillings breaking	☐	☐
-Grinding or clenching teeth	☐	☐
-Bleeding, swollen or irritated gums	☐	☐
-Loose, chipped or shifting teeth	☐	☐
-Bad breath	☐	☐
Do you know or have you been told that you snore?	☐	☐
Do you smoke or use chewing tobacco? How much? For how long?	☐	☐
Do you have or have you had any of the following? (New Patients Only)		
-Dentures	☐	☐
-Partial dentures	☐	☐
-Braces	☐	☐
-Gum treatments	☐	☐

	Yes	No
If you could whiten your teeth for a cost anyone could afford, would you do it?	☐	☐
If I could change my smile, I would:		
-Make them whiter	☐	☐
-Make them straighter	☐	☐
-Close spaces	☐	☐
-Repair chipped teeth	☐	☐
-Replace black metal fillings with tooth colored restorations	☐	☐
-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

What is the most important thing to you about your dental visit today?

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

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	☐ HPV Positive
☐ Diabetes	☐ Hepatitis C	☐ Radiation (head/neck)	☐ Other
☐ Dizziness	☐ High Blood Pressure	☐ Respiratory Problems	

Do you have any of the following drug allergies?

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

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

_____

Are you taking any medications? What?

_____

Family Physician _____ **Phone Number** _____

Is there any other medical or dental information we should know about?_____

Patient Signature *(Parent of Child)* _____ **Dentist Signature** _____ **Date** _____

Patient Name *(please print)* _____