NAME:_____

DENTAL HISTORY

What is the reason for your visit today?_____
Date of Last Dental Visit_____ Last Dental Cleaning_____ Last Full Mouth X-rays _____
What was done at your last dental visit?_____
Previous Dentist's Name_____ Telephone_____
Address_____
How often do you have dental examinations?_____
How often do you brush your teeth?_____ How often do you floss?_____
What other dental aids do you use? (toothpick, etc.) _____
Do you have any dental problems now (pain, sensitivity, broken teeth, esthetics, etc.)? Yes No
If yes, please describe:_____

Are any of your teeth sensitive to:		Do you:		Have you experienced:	
Hot or Cold?	Y N	Clench or grind your teeth while awake or asleep?	Y N	Clicking or popping of the jaw?	Y N
Sweets?	Y N			Pain? (joint, ear, side of face)	Y N
Biting or Chewing?	Y N	Bite your lips or cheeks regularly?	Y N	Difficulty in opening or closing?	Y N
Have you noticed any mouth odors or bad tastes?	Y N	Hold foreign objects with your teeth? (pens,pipe,pins,fingernails,etc)	Y N	Difficulty in chewing on either side of the mouth?	Y N
Do you frequently get cold sores or any other oral lesions?	Y N	Mouth breathe while awake or asleep?	Y N	Headaches, neckaches, shoulder aches?	Y N
		Have tired jaws, esp. in the morning?	Y N	Sore muscles (neck, shoulders)?	Y N
Do your gums bleed or hurt?	Y N	Smoke or chew tobacco?	Y N	Do you like the way your teeth look, including their shape and color?	Y N
Have your parents experienced gum disease or tooth loss?	Y N	Have you ever had:		Would you like to keep all of your teeth all of your life?	Y N
Have you noticed any loose teeth or change in your bite?	Y N	Orthodontic treatment (braces)?	Y N		
		Oral Surgery or extractions?	Y N		
		Gum treatment or gum surgery?	Y N	Do you feel nervous about having dental treatment?	Y N
Does food tend to become caught between your teeth?	Y N	Your teeth ground or bite adjusted?	Y N		
		A bite plate or mouth guard?	Y N	If so, what is your biggest concern? _____	
If yes, where?_____		A serious injury to the mouth or head?	Y N		
Have you ever whitened your teeth with any product?	Y N	If so, describe, including cause_____ _____ _____		Have you ever had an upsetting dental experience? If yes, please describe_____ _____	Y N
Is there anything else about having dental treatment that you would like us to know?					Y N

If yes, please describe_____
_____

MEDICAL HISTORY

Physician's name_____Address_____Date of last physical_____
Are you under the care of a physician? Y N If yes, for what?_____
Are you taking any medications at this time? Y N If yes, list medicines and dosages_____
_____

Have you ever had any of the following?					
Heart problems	Y N	Bulimia	Y N	GERD or Reflux problems	Y N
High blood pressure	Y N	Epilepsy	Y N	Special diet	Y N
Low blood pressure	Y N	Headaches	Y N	Swollen neck glands	Y N
Rheumatic fever	Y N	Hepatitis, Jaundice or Liver disease	Y N	Stroke	Y N
Mitral valve prolapse	Y N	Cancer	Y N	Ulcer	Y N
Heart murmur	Y N	Psychiatric care	Y N	Hemophilia	Y N
Circulatory problems	Y N	Nervous problems	Y N	Chemical dependency	Y N
Blood disease	Y N	Kidney disorders	Y N	Venereal disease	Y N
Radiation treatments	Y N	Arthritis	Y N	AIDS or HIV positive	Y N
Artificial heart valves or joints	Y N	Sinus problems	Y N	Diabetes	Y N
		Back problems	Y N	Respiratory disease (explain)_____	Y N

Are you allergic to any foods, medications, topicals, creams, latex or anesthetics? Y N If yes, please list all allergies:
_____

WOMEN - Are you pregnant or do you think you might be? Y N If yes, what month?_____ Are you nursing? Y N

If patient is a child, what is his/her current weight?_____pounds

Is there anything else we should know about your medical history?_____
_____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits for which I am entitled. I will not hold my dentist or any member of her staff responsible for any errors or omissions that I may have made in the completion of this form.

DATE_____ SIGNATURE_____

All the above information is necessary and will be held in the strictest of confidence.