Dental History

Patient Name: _____ Birthday: _____

1) **Please share the following dates:**

Your last cleaning: _____
Your last Bitewing X-Rays: _____
Your last Panorex or Full Mouth X-ray: _____

2) **Do you have or have you had any of the following?**

Denture/s: Yes / No Partial Denture/s: Yes / No
Periodontal (gum) treatments: Yes / No Braces: Yes / No

3) Name of Previous Dentist: _____ City/State: _____ Phone number: _____
4) I am changing dentists because: Moved to this area _____Inadequate care _____ Dr. or staff personality, communication problem _____ Fee concern _____

5) Please check any of the following problems that apply to you:	**YES**	**NO**
Sensitivity (hot, cold, sweet, pressure)	___	___
Where? (YOUR: upper left, lower left, upper right, lower right)		
Tooth pain or ache	___	___
Headaches, earaches, neck pain	___	___
Jaw joint pain	___	___
Grinding or clenching teeth	___	___
Teeth or filling breaking	___	___
Bleeding, swollen or irritated gums	___	___
Loose, tipped or shifting teeth	___	___
Bad breath	___	___
Snoring	___	___
Fear of the dentist or treatment	___	___

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

7) If I could change my smile, I would:
Make it whiter _____ Make it Straighter _____
Close Spaces _____ Repair chipped tooth _____
Replace missing teeth _____ Smile Makeover _____

8) I have avoided dental care in the past because of:
Lack of concern_____ Missing work/school time _____
Cost of treatment _____ Trust Factor _____
Fear of: _____

*If more room is needed to write, please use the back of this form.

Medical History

Emergency Contact/s: _____ _____ Phone: _____ Phone: _____

Are you taking any medicines including non-prescription medicines? Yes or No
Please provide us a separate list of all medications (including over the counter) or you may list them:
_____
_____

Are you under a physician's care? What for? _____
Name of Family Physician: _____

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

___ Aspirin or similar meds
___ Penicillin or other antibiotics
___ Barbiturates, sedatives or sleeping pills
___ Metals of any kind
___ Local anesthetic like Novocain
___ Codeine or similar meds
___ Latex or rubber
___ Other: _____

Please check any of the following problems/conditions that you *have or have had a history of*:

____ AIDS/ HIV
____ Alllergies(Seasonal)
____ Angina (Chest pain)
____ Arthritis
____ Artificial Valve Replacement
____ Asthma / COPD / Emphysema
____ Bleeding problems
____ Blood Pressure (high / low)
____ Cancer / Tumors
____ Chemotherapy
____ Depression
____ Diabetes
____ Drug Abuse / Alcoholism
____ Eating Disorders, Bulimia, Anorexia
____ Epilepsy / Seizures / MS
____ Glaucoma
____ Heart Attack
____ Heart Infection
____ Heart Surgery
____ Heart Trouble
____ Hepatitis, Jaundice or Liver Disease

____ Hospitalized / Surgical Operation
_____
_____
____ Joint Replacement
How long ago: _____
____ Kidney Trouble
____ Lung Disease
____ Nursing
____ Pacemaker
____Pregnant
How far along: _____
____ Radiation
____ Sinus Problems
____ Sleep Apnea
____ Snoring
____ Stomach Ulcers / Reflux / IBS
____ Stroke
____ Thyroid Problems
____ Tobacco use
OTHER:
_____
_____