

PATIENT NAME _____ Birth Date _____

Name of Medical Doctor: _____ Dr's Address: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

DENTAL HISTORY

Yes No

- 1. Do you have a specific dental problem? Describe _____ Yes No
- 2. Do you think you have active decay or gum disease? _____ Yes No
- 3. Do you brush and floss on a routine basis? _____ Yes No
- 4. Do your gums ever bleed? _____ Yes No
- 5. Are your teeth sensitive to hot or cold liquids/foods? _____ Yes No
- 6. Are your teeth sensitive to sweet or sour liquids/foods? _____ Yes No
- 7. Do you feel pain to any of your teeth? _____ Yes No
- 8. Do you ever have clicking, popping, or discomfort in the jaw joint? _____ Yes No
- 9. Do you clench or grind your teeth? _____ Yes No
- 10. Do you bite your lips or cheeks frequently? _____ Yes No
- 11. Have you had any orthodontic work? _____ Yes No
- 12. Have you ever had instruction on the correct method of brushing and flossing? _____ Yes No
- 13. What would you like to change about your smile? _____ Yes No
- 14. Date of last full mouth X-rays _____ Previous dental visit _____
- 15. Previous dentist _____ Phone number of previous dentist _____

MEDICAL HISTORY

Yes No

- 16. Are you under medical treatment? Why? _____ Yes No

Physician _____ Phone _____
- 17. Have you ever been hospitalized or had a major operation? Describe _____ Yes No
- 18. Have you ever had a serious injury to your head or neck? Describe _____ Yes No
- 19. Do you use tobacco? Yes No
- 20. Do you use alcohol, cocaine, or other drugs? Which? _____ Yes No
- 22. Women (Please check) Pregnant Nursing Taking birth control pills

22. Are you allergic to or have any reactions to the following?

- | | | | |
|--|-------------------------------------|----------------------------------|--------------------------------------|
| Yes No | Yes No | Yes No | Yes No |
| <input type="checkbox"/> Local Anesthetics | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine | <input type="checkbox"/> Acrylic | <input type="checkbox"/> Other _____ |

23. Do you now have or have you ever had any of the following?

- | | | | |
|--|--|---|--|
| Yes No | Yes No | Yes No | Yes No |
| <input type="checkbox"/> Artificial Heart Valve* | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Heart Murmur* | <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Joint Replacement* | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Mitral Valve Prolapse * | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Rheumatic Fever* | <input type="checkbox"/> Hearing Disorder | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pregnancy | |

MEDICATIONS

Please list all medications that you are now taking:

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

X _____
Signature of Patient, Parent or Guardian Date _____