DENTAL HISTORY

Please check the following :	YES	NO
-Sensitivity (hot, cold, sweet) Where? UR LR UL LL	☐	☐
-Headaches, ear aches, neck or jaw joint pain	☐	☐
-Mouth ulcers or cold sores	☐	☐
-Teeth or fillings breaking	☐	☐
-Grinding or clenching teeth	☐	☐
-Bleeding, swollen or irritated gums	☐	☐
-Loose, tipped or shifting teeth	☐	☐
-Bad breath	☐	☐
Do you have or have you had any of the following?		
-Dentures	☐	☐
-Partial dentures	☐	☐
-Braces	☐	☐
-Gum treatments	☐	☐

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 _____

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

	YES	NO
If you could whiten your teeth for a cost anyone could afford, would you do it?	☐	☐
Do you smoke or use chewing tobacco? How much? For how long?	☐	☐
If I could change my smile, I would:		
-Make my teeth whiter	☐	☐
-Make my teeth straighter	☐	☐
-Close spaces	☐	☐
-Replace metal fillings with tooth colored restorations	☐	☐
-Repair chipped teeth	☐	☐
-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

Why did you leave your previous dentist?

_____

_____

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

MEDICAL HISTORY

Please check any of the following that apply to you:

☐ Allergies (Seasonal)	☐ Excessive Bleeding
☐ Anemia	☐ Glaucoma
☐ Artificial Heart Valve	☐ Heart Conditions
☐ Artificial Joints	☐ Heart Murmur
☐ Asthma	☐ Hepatitis A
☐ Blood Disease	☐ Hepatitis B
☐ Bruise Easily	☐ Hepatitis C
☐ Cancer	☐ High Blood Pressure
☐ Chemotherapy	☐ HIV/AIDS
☐ Diabetes	☐ Jaundice
☐ Dizziness/Fainting	☐ Kidney Disease
☐ Drug Addiction	☐ Liver Disease
☐ Emphysema	☐ Mitral Valve Prolapse
☐ Nervousness/Depression	☐ Ulcers
☐ Pacemaker	☐ OTHER (please list):
☐ Phen Fen (1 month +)	_____
☐ Radiation (head/neck)	_____
☐ Respiratory Problems	_____
☐ Rheumatic Fever	_____
☐ Rheumatism	_____
☐ Scarlet Fever	_____
☐ Seizures	**For WOMEN Only**
☐ Stomach Problems	❑ Birth Control Pills
☐ Stroke	❑ Breast-feeding
☐ Thyroid Disease	❑ Pregnant
☐ Tuberculosis	1-3 mos,3-6 mos,6-9mos,

Do you have an allergy to any of the following?

☐ Aspirin	☐ Codeine	**What medications are you currently taking?**
☐ Erythromycin	☐ Other:	
☐ Latex	_____	
☐ Local Anesthetic	_____	_____
☐ Nitrous Oxide	_____	_____
☐ Penicillin	_____	_____

Are you under a physician's care? For what?

_____

_____

Family Physician _____ **Phone Number** _____

Patient Signature Date Dentist Signature Date