

DENTAL HISTORY

Please check the following :

YES NO

- Sensitivity (hot, cold, sweet) Where? _____ ☐ ☐
- 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? _____

If you could whiten your teeth for a cost anyone could afford, would you do it?

YES NO
☐ ☐

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:

- | | | |
|---|--|---|
| <input type="checkbox"/> Allergies (Seasonal) | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Nervousness/Depression |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Heart Conditions | <input type="checkbox"/> Phen Fen (1 month +) |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Radiation (head/neck) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tuberculosis |

☐ Ulcers

☐ OTHER (list): _____

Do you have an allergy to any of the following?

☐ Aspirin ☐ Penicillin

☐ Erythromycin ☐ Latex

☐ Local Anesthetic

☐ Nitrous Oxide

☐ Codeine

☐ Other: _____

For WOMEN Only

☐ Birth Control Pills

☐ Breast-feeding

☐ Pregnant 1-3 mos, 3-6 mos, 6-9 mos,

Are you under a physician's care? Y/N For what? _____ **Medications you are taking?** _____

Family Physician: _____ **Phone number:** _____

Is there any other Medical or Dental Information we should know about? _____

Patient Name: _____ **Signature:** _____ **Date:** _____

Team member: _____