

DENTAL HISTORY

Patient Name
Patient Account Number

Medical Alert

*Welcome! So that we may provide you with the best possible care
Please complete both sides of this medical/dental history form.
All information is completely confidential.*

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: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone: _____

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? (Interplak, toothpick, etc.) _____

Do you have dental problems now? YES NO

If yes, please describe: _____

Are your teeth sensitive to:

- | | | |
|--|-----|----|
| Hot or cold? | Yes | No |
| Sweets? | Yes | No |
| Biting or Chewing? | Yes | No |
| Have you noticed any mouth odors or bad tastes? | Yes | No |
| Do you frequently get cold sores, blisters or any other oral lesions ? | Yes | No |

Do your gums bleed or hurt?

- | | | |
|--|-----|----|
| Have your parents experienced gum disease or tooth lose? | Yes | No |
| Have you noticed any loose teeth or change in your bite? | Yes | No |
| Does food tend to be caught in between your teeth? | Yes | No |
| If yes, where? _____ | | |

Do You:

- | | | |
|--|-----|----|
| Clench or grind your teeth while awake or asleep? | Yes | No |
| Bite your lips or cheeks regularly? | Yes | No |
| Hold foreign objects with your teeth?
(pencils, pipe, pins, nails, fingernails) | Yes | No |
| Mouth breathe while awake or asleep? | Yes | No |
| Have tired jaws, especially in the morning? | Yes | No |
| Smoke/chew tobacco? | Yes | No |

Have you ever had:

- | | | |
|--|-----|----|
| Orthodontic treatment? | Yes | No |
| Oral Surgery? | Yes | No |
| Periodontal treatment? | Yes | No |
| Your teeth ground or the bite adjusted? | Yes | No |
| A bite plate or mouth guard? | Yes | No |
| A serious injury to the mouth or head? | Yes | No |
| If so, please describe, including cause: _____ | | |

Have you ever experienced:

- | | | |
|---|-----|----|
| Clicking or popping of the jaw? | Yes | No |
| Pain? (joint, ear, side of face) | Yes | No |
| Difficulty in opening or closing the mouth? | Yes | No |
| Headaches, neck aches or shoulder aches? | Yes | No |
| Sore muscles? (neck or shoulders) | Yes | No |

Are you satisfied with your teeth's appearance?

- | | | |
|--|-----|----|
| Would you like to keep all of your teeth all of your life? | Yes | No |
| Do you feel nervous about having dental treatment? | Yes | No |
| If so, what is your biggest concern? _____ | | |
| Have you ever had an upsetting dental experience? | Yes | No |
| If yes, please describe _____ | | |

Is there anything else about having dental treatment that you would like us to know? **YES NO**

If yes, please describe: _____

PLEASE COMPLETE THE OTHER SIDE

MEDICAL HISTORY

Patient Name _____

Patient Account Number _____

Medical Alert _____

1. Have you been under the care of a medical doctor during the past two years? **YES NO**

If yes, for what? _____

Physician's Name _____

Address _____ City _____ State _____ Zip _____

2. Have you taken any medication or drugs during the past two years? **YES NO**

3. Are you taking any medication, drugs or pills now? **YES NO**

If yes, please list name and dosage: _____

4. Are you aware of having an allergic (or adverse reaction) to any medication or substance? **YES NO**

If yes, please list: _____

5. Have you been a patient in the hospital during the past five years? **YES NO**

6. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Hepatitis A (infectious) B (serum)	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S.	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No	Contact Lenses	Yes	No	Cold Sores/Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Blood Transfusion	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Hemophilia	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Hay Fever	Yes	No	Liver Disease	Yes	No
Cortisone Medicine	Yes	No	Latex Sensitivity	Yes	No	Yellow Jaundice	Yes	No
Swollen Ankles	Yes	No	Allergies or Hives	Yes	No	Neurological Disorders	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Artificial Joints (Hip, Knee, etc.)	Yes	No	Chemotherapy	Yes	No	Nervous/Anxious	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Psychiatric/Psychological Care	Yes	No

7. Do you use more than two pillows to sleep? **YES NO**

8. Have you lost or gained more than 10 pounds in the past year? **YES NO**

9. Do you have or have had any disease, condition, or problem not listed? **YES NO**

If yes, please list: _____

10. **Women:** Are you: **Pregnant?** Yes, _____ months No **Nursing?** Yes No

Taking Birth Control Pills? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date _____

We appreciate the opportunity to serve you and others whom you may refer as a result of your experience here. You will find us to be very open and straightforward regarding fees and treatment. Our desire is to provide you with the highest quality care available in a setting we believe is comfortable and technologically advanced. Modern dentistry can be a very pleasant experience!