Patient name:_____ DOB: __/__/__

Current Dental Health

Please check if any of the following problems apply to you:

[ ] Sensitivity
[ ] Tooth pain or discomfort when chewing
[ ] Headaches, ear aches, neck pain
[ ] Mouth ulcers or cold sores
[ ] Jaw joint pain
[ ] Broken tooth or fillings
[ ] Grinding or clenching teeth
[ ] Bleeding, swollen or irritated gums
[ ] Loose, tipped or shifted teeth
[ ] Bad breath or bad taste in your mouth

Do you or have you had any of the following?

[ ] Dentures
[ ] Partial dentures
[ ] Braces
[ ] Gum treatments
[ ] Implants
[ ] **Required to take antibiotics prior to dental treatment**

Do you smoke or use chewing tobacco? [ ] yes [ ] no
How much?_____For how long? _____

If you could change your smile, you would:

[ ] Make my teeth whiter
[ ] Make my teeth straighter
[ ] Close spaces
[ ] Fix crowding
[ ] Replace metal fillings with tooth colored fillings
[ ] Repair chipped teeth
[ ] Replace missing teeth
[ ] Replace old crowns that don't match
[ ] Have a smile makeover

Please share the following dates:

Your last cleaning:_____/_____/_____
Your last oral cancer screening:_____/_____/_____
Your last set of complete x-rays:_____/_____/_____
Previous Dentist / Dental Office _____

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

_____

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

_____

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? [ ] yes [ ] no
  Name and Number: _____
- Have you ever been hospitalized or had a major operation? [ ] yes [ ] no
  Please explain: _____
- Have you ever had a serious head or neck injury? [ ] yes [ ] no
  Please explain: _____
- Are you taking any medications, pills, or drugs? [ ] yes [ ] no
  Please List all Medications: _____

_____

- Have you ever taken Fosamax, Boniva, Actonel, or any medications containing bisphosphonates? [ ] yes [ ] no
- Are you on a special diet? [ ] yes [ ] no **Please Explain:** _____
- Do you use controlled substances? [ ] yes [ ] no **Please list:** _____

Women: Are you

[ ] Pregnant/Trying to get pregnant? [ ] Taking oral contraceptives? [ ] Nursing?

Are you allergic to any of the following?

[ ] Aspirin [ ] Penicillin [ ] Codeine [ ] Local Anesthetics [ ]Acrylic [ ] Metal [ ] Latex [ ] Sulfa Drugs [ ] Other

If other, please explain: _____

Please check if you have, or have had, any of the following:

[ ] AIDS/HIV Positive
[ ] Alzheimer's Disease
[ ] Anaphylaxis
[ ] Anemia
[ ] Angina
[ ] Arthritis/Gout
[ ] Artificial Health Valve
[ ] Artificial Joint
[ ] Asthma
[ ] Blood Disease
[ ] Breathing Problem
[ ] Bruise Easily
[ ] Cancer
[ ] Chemotherapy
[ ] Chest Pains
[ ] Cold Sores
[ ] Congenital Heart Disorder
[ ] Convulsions
[ ] Diabetes
[ ] Drug Addiction
[ ] Dry mouth
[ ] Emphysema
[ ] Epilepsy or Seizures
[ ] Excessive Bleeding
[ ] Fainting spells/ Dizziness
[ ] Heart Attack/ Failure
[ ] Heart Murmur
[ ] Heart Pacemaker
[ ] Heart Trouble/ Disease
[ ] Hemophilia
[ ] Hepatitis A
[ ] Hepatitis B or C
[ ] Herpes
[ ] High Blood Pressure
[ ] High Cholesterol
[ ] Hives or Rash
[ ] Hypoglycemia
[ ] Irregular Heartbeat
[ ] Kidney Problems
[ ] Leukemia
[ ] Liver Disease
[ ] Low Blood Pressure
[ ] Lung Disease
[ ] Mitral Valve Prolapse
[ ] Osteoporosis
[ ] Pain in Jaw joints
[ ] Parathyroid Disease
[ ] Psychiatric Care
[ ] Radiation Treatments
[ ] Renal Dialysis
[ ] Rheumatism
[ ] Shingles
[ ] Sickle Cell Disease
[ ] Sinus Trouble
[ ] Stomach/ Intestinal Disease
[ ] Stroke
[ ] Swelling of Limbs
[ ] Thyroid Disease
[ ] Tonsillitis
[ ] Tuberculosis
[ ] Tumors or Growths
[ ] Ulcers
[ ] Venereal Disease
[ ] Yellow Jaundice
[ ] Other serious illnesses not listed above, explain:

_____
_____
_____
_____
_____
_____
_____
_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is <u>my responsibility</u> to inform the dental office of any changes in medical status at every dental

Signature of Patient, Parent, or Guardian _____ **Date** _____