DENTAL HISTORY

Please check any of the following problems that apply to you.

	Yes	No
-Sensitivity (hot: cold. sweet. pressure)	☐	☐
Where? UR LR UL LL		
-Headaches. earaches. neck pain	☐	☐
-Jaw joint pain	☐	☐
-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	☐	☐
-Periodontal (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 _____

	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 it whiter	☐	☐
-Make it straighter	☐	☐
-Close spaces	☐	☐
-Replace black 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

Where do you want your dental health to be?
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 future smile and dental health? _____

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

MEDICAL HISTORY

Please check any of the following problems/conditions that apply to you:

	YES	NO		YES	NO		YES	NO		YES	NO
AIDS	☐	☐	Dizziness	☐	☐	HIV Positive	☐	☐	Scarlet Fever	☐	☐
Allergies (Seasonal)	☐	☐	Drug Addiction	☐	☐	HPV (Human Papilloma Virus)	☐	☐	Seizures	☐	☐
Anemia	☐	☐	Emphysema	☐	☐	Jaundice	☐	☐	Sinus Problems	☐	☐
Angina (Chest pain)	☐	☐	Epilepsy	☐	☐	Jaw Joint Pain	☐	☐	Sleep Apnea	☐	☐
Arthritis	☐	☐	Excessive Bleeding	☐	☐	Kidney Disease	☐	☐	Stomach Problems	☐	☐
Artificial Heart Valve	☐	☐	Fainting	☐	☐	Liver Disease	☐	☐	Stroke	☐	☐
Artificial Joints	☐	☐	Glaucoma	☐	☐	Low Blood Pressure	☐	☐	Thyroid Disease	☐	☐
Asthma	☐	☐	Heart Conditions	☐	☐	Mitral Valve Prolapse	☐	☐	Tuberculosis	☐	☐
Blood Disease	☐	☐	Heart Lesions (Congenital)	☐	☐	Nervousness/Depression	☐	☐	Ulcers	☐	☐
Bruise Easily	☐	☐	Heart Murmur	☐	☐	Pacemaker	☐	☐	Venereal Diseases	☐	☐
Cancer	☐	☐	Heart Surgery	☐	☐	Pregnant Currently	☐	☐	Other _____		
Cervical Cancer	☐	☐	Hepatitis A	☐	☐	Radiation (head/neck)	☐	☐			
Chemotherapy	☐	☐	Hepatitis B	☐	☐	Respiratory Problems	☐	☐			
Cortisone Medication	☐	☐	Hepatitis C	☐	☐	Rheumatic Fever	☐	☐			
Diabetes	☐	☐	High Blood Pressure	☐	☐	Rheumatism	☐	☐			

Are you allergic or have you reacted adversely to any of the following medications?

	YES	NO		YES	NO		YES	NO		YES	NO
Aspirin	☐	☐	Percodan	☐	☐	Tetracycline	☐	☐	Valium	☐	☐
Darvon	☐	☐	Latex	☐	☐	Codeine	☐	☐	Penicillin	☐	☐
Nitrous Oxide	☐	☐	Local Anesthetic	☐	☐	Erythromycin	☐	☐	Sulfa	☐	☐

Other _____

Have you ever taken any the following medications?

	YES	NO		YES	NO
Actonel	☐	☐	Zometa	☐	☐
Aredia	☐	☐	Boniva	☐	☐
Fosamax	☐	☐	Herbal Supplements	☐	☐
Reclast	☐	☐			

Are you under a physician's care? What for?

_____

What medications are you currently taking?

_____

Family Physician Phone Number

_____

Consent:

The undersigned herby authorizes Doctor to take X-rays. study models. photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment. medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read. understand and agree to the above terms and conditions.

Patient Signature (Parent if child) **Date** **Dentist Signature**