DENTAL HISTORY

Patient Name______________________________

Please check any of the following that apply to you:

- ☐ Sensitivity (hot, cold, sweet)
- ☐ 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 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? ________________

Do you smoke or use chewing tobacco? How much? For how long? ________________________

If you could change your smile, you would:

- ☐ Make my teeth whiter
- ☐ Make my teeth straighter
- ☐ Close spaces
- ☐ Replace metal fillings with tooth colored fillings
- ☐ 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)
- ☐ Anemia
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Excessive Bleeding
- ☐ Glaucoma
- ☐ Heart Conditions
- ☐ Heart Murmur
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Anxiety
- ☐ Depression
- ☐ Pacemaker
- ☐ Radiation (head/neck)
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Other (please list):

____

____

____

____

For Women Only:

- ☐ Birth Control Pills
- ☐ Breast Feeding
- ☐ Pregnant
  - ☐ 1-3 months
  - ☐ 3-6 months
  - ☐ 6-9 month

What medications are you currently taking?

____

____

Are you under a physician's care?

☐ Yes ☐ No

For what condition?

____

Physician Name: ____________

Physician Phone: ____________

Do you have an allergy to any of the following?

- ☐ Aspirin
- ☐ Nitrous Oxide
- ☐ Erythromycin
- ☐ Local Anesthetic
- ☐ Latex
- ☐ Codeine
- ☐ Penicillin
- ☐ Other

Today's Blood Pressure (staff entry) ____/____

Signature (Parent or Guardian) ____________ **Date** ______ **Dentist Signature** ____________ **Date** ______