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? ____________________

	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 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:

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

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,6-9mos,

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: ___________________________