DENTAL HISTORY

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

- -Sensitivity (hot, cold, sweet) ☐
- -Tooth pain or discomfort when chewing ☐
- -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 or bad taste in your mouth ☐

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 _____

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 them brighter ☐
- -Make them straighter ☐
- -Close spaces ☐
- -Replace black metal fillings with natural, 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 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 that apply to you:

- ☐ AIDS
- ☐ Allergies (Seasonal)
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Dizziness
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Heart Conditions
- ☐ Heart Lesions (Congenital)
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Jaundice
- ☐ Jaw Joint Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Nervousness/Depression
- ☐ Pacemaker
- ☐ Phen Fen (1 month +)
- ☐ Pregnant Currently
- ☐ Radiation (head/neck)
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Diseases
- ☐ Other

Do you have any of the following drug allergies?

- ☐ Aspirin
- ☐ Codeine
- ☐ Darvon
- ☐ Erythromycin
- ☐ Nitrous Oxide
- ☐ Valium
- ☐ Percodan
- ☐ Penicillin
- ☐ Local Anesthetic
- ☐ Other

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

_____

Are you taking any medications? What?

_____

Family Physician _____ **Phone Number** _____

Is there any other medical or dental information we should know about? _____

Patient Signature (Parent or Guardian if a Minor)_____ **Date**_____