PLEASE COMPLETE ALL INFORMATION – THANK YOU!

PATIENT LAST NAME: _____ **PATIENT FIRST NAME:** _____

DENTAL HISTORY

Reason for today's visit: _____ Date of last dental visit: _____

Former dentist: _____ Date of last dental x-rays: _____

Please check if you have/had:

Bad breath	☐	Gums swollen, tender, or bleeding	☐	Have you ever had an allergic reactions	☐
Blisters on lips or mouth	☐	Head, neck, or jaw pain or aches	☐	to Novocaine, local or general anesthetics?	
Burning sensation on tongue	☐	Lip or cheek biting	☐	*If Yes, please explain:*	
Chew on one side of mouth	☐	Loose teeth or broken fillings	☐	_____	
Cigarette, pipe, or cigar smoking	☐	Mouth breathing	☐		
Smokeless tobacco	☐	Orthodontic treatment	☐	Have you had trouble from previous	☐
Dry mouth	☐	Nitrous Oxide	☐	dental care?	
Food collection between teeth	☐	Periodontal treatment	☐	*If Yes, please explain what happened:*	
Clench teeth	☐	Sensitivity to pressure or irritants	☐	_____	
Grind teeth	☐	(cold, heat, sweets)		_____	
Growths or sore spots in mouth	☐	How often do you floss? _____			
		How often do you brush? _____			

MEDICAL HISTORY

Physician's name: _____ Date of last visit: _____

Physician's address: _____

Have you ever had a blood transfusion? Yes ☐ If Yes, please describe: _____

Have you had any serious illnesses or operations? Yes ☐ If Yes, please give approximate dates: _____

Pregnant? Yes ☐ Due Date? _____ Nursing? Yes ☐ Birth Control Pills? Yes ☐

Please check if you have/had:

Allergies, hay fever, sinusitis	☐	Heart Problems	☐	Thyroid Problems	☐
Anemia	☐	Hepatitis?	☐	Tonsillitis	☐
Arthritis, Rheumatism	☐	Type: _____		Tuberculosis	☐
Artificial Heart Valves	☐	Herpes	☐	Tumor or Growth on Head/Neck	☐
Artificial Joints	☐	High Blood Pressure	☐	Ulcer	☐
Asthma	☐	Any Immune Deficiency (incl. HIV/AIDS)	☐	Venereal Disease	☐
Asthma: Required Hospitalization	☐	Jaundice	☐	Weight Loss, Unexplained	☐
Asthma: Used Steroids	☐	Kidney Disease	☐	Do you wear contact lenses?	☐
Bleeding abnormally with operation/surgery	☐	Low Blood Pressure	☐	Do you consume alcoholic beverages?	☐
Blood Disease, Clotting Disorders	☐	Mitral Valve Prolapse	☐	Are you currently under the care of a	☐
Cancer	☐	Osteopenia	☐	Physician?	
Chemical Dependency	☐	Osteoporosis	☐	Are you allergic/sensitive to Latex?	☐
Chemotherapy	☐	Pacemaker	☐	Allergic to penicillin, Aspirin or Other Drugs?	☐
Circulatory Problems	☐	Radiation Treatments	☐	*If Yes, please specify:*	
Cortisone Treatments	☐	Respiratory Disease	☐	_____	
Cough, persistent or bloody	☐	Rheumatic Fever	☐	_____	
Diabetes	☐	Scarlet Fever	☐	Are you currently taking any Medications?	☐
Emphysema	☐	Shortness of Breath	☐	*If Yes, please list:*	
Epilepsy	☐	Sinus Trouble	☐	_____	
Fainting	☐	Sickle Cell Anemia	☐	_____	
Glaucoma	☐	Skin Rash	☐	_____	
Headaches	☐	Stroke	☐	_____	
Heart Murmur	☐	Swelling of Feet/Ankles	☐	_____	

AUTHORIZATION AND RELEASE

I have read and answered the above questions to the best of my knowledge.

Patient/Guardian Signature: _____ Date: _____

Reviewed by: _____ Date: _____