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DENTAL HISTORY

Welcome to our office.

**So we may provide you with the best possible care, please complete this dental history form.
All information is entirely confidential.**

Reason for seeing the Doctor today ______

Date of last dental visit ______ Last dental cleaning ______ Last full mouth x-ray ______

What was done at your last dental visit? ______

Your previous Dentist's name ______ Address ______

City ______ State ______ Zip ______ Phone ______

How often do you see a dentist? ______ How often do you brush? ______ How often do you floss? ______

Do you use dental aids? (Toothpick, Interplak, etc.) ______

Do you have dental problems now? Yes ☐ No ☐ If yes, please describe ______

Are any of your teeth sensitive to:

	Yes	No
Hot or Cold?	Yes ☐	No ☐
Sweets?	Yes ☐	No ☐
Biting or Chewing?	Yes ☐	No ☐
Have you noticed any mouth odors or bad tastes?	Yes ☐	No ☐
Do you frequently get cold sores, blisters or any other oral lesions?	Yes ☐	No ☐
Do your gums hurt or bleed?	Yes ☐	No ☐
Have your parents experienced gum disease or tooth loss?	Yes ☐	No ☐
Have you noticed any loose teeth or change in your bite?	Yes ☐	No ☐
Does food become caught between your teeth?	Yes ☐	No ☐

If yes, where? ______

Do you:

	Yes	No
Clench or grind your teeth while awake or asleep?	Yes ☐	No ☐
Bite your lips or cheeks regularly?	Yes ☐	No ☐
Hold object with your teeth? (Pencils, pins, nails, etc.)	Yes ☐	No ☐
Mouth breath while asleep or awake?	Yes ☐	No ☐
Have tired jaws, especially in the morning?	Yes ☐	No ☐
Smoke/chew tobacco?	Yes ☐	No ☐
Snoring at night?	Yes ☐	No ☐
Interrupted breathing at night?	Yes ☐	No ☐
Unpleasant breath	Yes ☐	No ☐

Have you ever had:

	Yes	No
Orthodontic treatment?	Yes ☐	No ☐
Oral surgery?	Yes ☐	No ☐
Periodontal treatment?	Yes ☐	No ☐
Your teeth ground or the bite adjusted?	Yes ☐	No ☐
A bite plate or mouth guard?	Yes ☐	No ☐
A serious injury to the head or mouth?	Yes ☐	No ☐

If yes, describe, including the cause ______

Have you experienced:

	Yes	No
Clicking or popping of the jaw?	Yes ☐	No ☐
Pain? (Joint, ear, side of face)	Yes ☐	No ☐
Difficulty opening/closing the mouth?	Yes ☐	No ☐
Difficulty chewing on either side of your mouth?	Yes ☐	No ☐
Head, neck or shoulder aches?	Yes ☐	No ☐
Are you satisfied with the way your teeth look?	Yes ☐	No ☐
Would you like to keep all of your teeth all of your life?	Yes ☐	No ☐
Do you feel nervous about having dental treatment?	Yes ☐	No ☐

If yes, what is your biggest concern? ______

Have you ever had an upsetting dental experience? Yes ☐ No ☐

If yes, describe ______

Is there anything else about having dental treatment you would like us to know? ______

Patient Name **Account No.**

MEDICAL HISTORY

Have you been under the care of a medical doctor during the past two years? Yes ☐ No ☐

If yes, for what reason? ____________________

Physician's name ____________________ Phone ____________________

Address ____________________ City ____________ State ____________ Zip ____________

Have you taken any medication or drugs during the past two years? Yes ☐ No ☐

Are you currently taking any medication, drugs or pills? Yes ☐ No ☐

If yes, list name and dosage ____________________

Are you aware of having an allergic or adverse reaction to any medication or substance? Yes ☐ No ☐

If yes, describe ____________________

Have you been a patient in the hospital in the past five years? Yes ☐ No ☐

Please indicate which of the following you have had, or have at present. Circle Y for Yes, N for No.

Condition			Condition			Condition		
Heart Attack, Surgery or Disease	Y	N	Ulcers	Y	N	Hepatitis A (infectious) B (serum)	Y	N
Chest Pain	Y	N	Diabetes	Y	N	Venereal Disease	Y	N
Congenital heart Disease	Y	N	Thyroid Problems	Y	N	A.I.D.S.	Y	N
Heart Murmur	Y	N	Glaucoma	Y	N	H.I.V. Positive	Y	N
High Blood Pressure	Y	N	Contact Lenses	Y	N	Cold Sores/Fever Blisters	Y	N
Mitral Valve Prolapse	Y	N	Emphysema	Y	N	Blood Transfusion	Y	N
Artificial Heart Valve	Y	N	Chronic Cough	Y	N	Hemophilia	Y	N
Heart Pacemaker	Y	N	Tuberculosis	Y	N	Sickle Cell Disease	Y	N
Rheumatic Fever	Y	N	Asthma	Y	N	Bruise Easily	Y	N
Arthritis/Rheumatism	Y	N	Hay Fever	Y	N	Liver Disease	Y	N
Cortisone Medicine	Y	N	Latex Sensitivity	Y	N	Yellow Jaundice	Y	N
Swollen Ankles	Y	N	Allergies or Hives	Y	N	Neurological Disorders	Y	N
Stroke	Y	N	Sinus Trouble	Y	N	Epilepsy or Seizures	Y	N
Diet (Special/Restricted)	Y	N	Radiation Therapy	Y	N	Fainting or Dizzy Spells	Y	N
Artificial Joints (Hip, Knee, etc.)	Y	N	Chemotherapy	Y	N	Nervous/Anxious	Y	N
Kidney Trouble	Y	N	Tumors	Y	N	Psychiatric/Psychological Care	Y	N

Do you more than two pillows to sleep? Yes ☐ No ☐

Have you lost or gained more than 10 pounds in the last year? Yes ☐ No ☐

Do you have or have you had any disease, condition, or problem not listed above? Yes ☐ No ☐

If yes, describe ____________________

Women: Are you pregnant? Yes ☐- Months ____ No ☐ Nursing? Yes ☐ No ☐ Taking Birth Control Pills Yes ☐ No ☐

I understand the information on both sides of this form is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to be best of my knowledge. If further information is needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the Doctor of any change in my health or medication. the undersigned hereby 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 in correction with patient. I further authorize and consent that Doctor choose and employ such assistance as deemed fit.

Patient Signature ____________________ Date ____________

Parent/Responsible Party Signature ____________________ Date ____________