

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? Y N

Do you smoke or use chewing tobacco Y N
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:

- | | |
|--|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> AIDS <input type="checkbox"/> Allergies (Seasonal) <input type="checkbox"/> Anemia <input type="checkbox"/> Arthritis <input type="checkbox"/> Artificial Heart Valve <input type="checkbox"/> Artificial Joints <input type="checkbox"/> Asthma <input type="checkbox"/> Blood Disease <input type="checkbox"/> Bruise Easily <input type="checkbox"/> Cancer <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Diabetes <input type="checkbox"/> Dizziness | <ul style="list-style-type: none"> <input type="checkbox"/> Drug Addiction <input type="checkbox"/> Emphysema <input type="checkbox"/> Excessive Bleeding <input type="checkbox"/> Fainting <input type="checkbox"/> Glaucoma <input type="checkbox"/> Heart Condition <input type="checkbox"/> Heart Lesions (Congenital) <input type="checkbox"/> Heart Murmur <input type="checkbox"/> Heart Surgery <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C <input type="checkbox"/> High Blood Pressure |
|--|--|

Do you have any of the following allergies?

- | | |
|--|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> Aspirin <input type="checkbox"/> Latex <input type="checkbox"/> Nitrous Oxide <input type="checkbox"/> Percodan <input type="checkbox"/> Local Anesthetic | <ul style="list-style-type: none"> <input type="checkbox"/> Codeine <input type="checkbox"/> Erythromycin <input type="checkbox"/> Valium <input type="checkbox"/> Penicillin <input type="checkbox"/> Other _____ |
|--|---|

- | | |
|--|---|
| <ul style="list-style-type: none"> <input type="checkbox"/> HIV Positive <input type="checkbox"/> Jaundice <input type="checkbox"/> Jaw Joint Pain <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Mitral Valve Prolapse <input type="checkbox"/> Nervousness/Depression <input type="checkbox"/> Pacemaker <input type="checkbox"/> Phen Fen (1 month +) <input type="checkbox"/> Pregnant Currently <input type="checkbox"/> Radiation (head/neck) | <ul style="list-style-type: none"> <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Rheumatism <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Seizures <input type="checkbox"/> Stomach Problems <input type="checkbox"/> Stroke <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Ulcers <input type="checkbox"/> Venereal Diseases <input type="checkbox"/> Respiratory Problems <input type="checkbox"/> Other _____ |
|--|---|

Are you under a physician's care? Y N What for? _____

Are you taking medications? Y N What? _____

Family Physician _____ Phone Number _____

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

PATIENT Signature (Parent of Child) _____ Date: _____