

Dental History

Why have you come to the dentist today? _____

Previous Dentist: _____ Date of last visit: _____

- Are you currently in pain? Yes No
- Do you require antibiotics before dental treatments? Yes No
- Your current dental health is Good Fair Poor
- Do you floss daily? Yes No Brush daily? Yes No
- Are you happy with the way your smile looks? Yes No
- Are you teeth sensitive to hot or cold? Yes No
- Would you like fresher breath? Yes No
- Would you like whiter teeth? Yes No
- Do your gums ever bleed? Yes No
- Have you ever had periodontal disease? Yes No

What would you change about your smile? _____

Medical History

Do you have a personal physician? Yes No Your current physical health is: Good Fair Poor

Physician's Name: _____ Phone #: (_____) _____

Address: _____
Street City State Zip

- Are you currently under the care of a physician? Yes No If yes please explain: _____
- Do you smoke or use tobacco in any other form? Yes No _____
- Have you ever taken Phen-Fen, Redux or Pondimin? Yes No _____
- For Women: Are you taking birth control pills? Yes No _____
- Are you pregnant? Unsure Yes No Week #: _____ Are you nursing? Yes No

Do you currently have, or have you experienced the following?

(Please circle yes or no to each of the conditions listed)

- | | | | | |
|-----------------------------|-----------------------------|-------------------------|---------------------------|-------------------------|
| Y N Abnormal Bleeding | Y N Colitis | Y N Hay Fever | Y N Liver Disease | Y N Shingles |
| Y N Alcohol Abuse | Y N Congenital Heart Defect | Y N Headaches | Y N Low Blood Pressure | Y N Sickle Cell Disease |
| Y N Anemia | Y N Diabetes | Y N Heart Attack | Y N Lupus | Y N Sinus Problems |
| Y N Arthritis | Y N Difficulty Breathing | Y N Heart Murmur | Y N Mitral Valve Prolapse | Y N Steroid Therapy |
| Y N Artificial Bones/Joints | Y N Drug Abuse | Y N Heart Surgery | Y N Pacemaker | Y N Stroke |
| Y N Artificial Valves | Y N Emphysema | Y N Hemophilia | Y N Persistent Cough | Y N Thyroid Problems |
| Y N Asthma | Y N Epilepsy | Y N Hepatitis | Y N Psychiatric Problems | Y N tonsillitis |
| Y N Blood Transfusion | Y N Ever Hospitalized | Y N Herpes | Y N Radiation Problems | Y N Tuberculosis (TB) |
| Y N Cancer | Y N Fainting Spells | Y N High Blood Pressure | Y N Rheumatic Fever | Y N Ulcers |
| Y N Chemotherapy | Y N Fever Blisters | Y N HIV+/AIDS | Y N Scarlet Fever | Y N Venereal Disease |
| Y N Chicken Pox | Y N Glaucoma | Y N Kidney Problems | Y N Seizures | Y N High Cholesterol |

Please mark yes or no if you are taking any of these medications listed below:

- | | | | | |
|--------------------|-------------------------------|------------------------|-----------------------------|-------------------|
| Y N Acetaminophen | Y N Steroids/Cortisone | Y N Blood Thinners | Y N Digitalis/Heart Medicat | Y N Tranquilizers |
| Y N Antibiotics | Y N Blood Pressure Medication | Y N Nitroglycerin | Y N Insulin/Diabetes Drugs | Y N Aspirin |
| Y N Antihistamines | Y N Cold Remedies | Y N Recreational Drugs | Y N Thyroid Medicine | |

If you are taking any prescription/over the counter drugs, Please list: _____

Are you allergic to any of the following?

- | | | | | | |
|------------------|------------------------|--------------------|----------------|-----------------|------------------|
| Y N Aspirin | Y N Codeine | Y N Erythromycin | Y N Latex | Y N Sedatives | Y N Tetracycline |
| Y N Barbiturates | Y N Dental Anesthetics | Y N Jewelry/Metals | Y N Penicillin | Y N Sulfa Drugs | Y N Other |

Please list any additional that cause allergic reactions: _____

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I assign the Doctor all insurance benefits otherwise payable to me. I understand that I am responsible for payment at the time services are rendered. I authorize the use of my signature whether manual or electronic.

PAYMENT DUE AT TIME OF SERVICE

Signature

Date