

DENTAL HISTORY

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

- Sensitivity (hot, cold, sweet)
Where? UR LR UL LL
- 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

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 _____

What is the most important thing to you about your future smile and dental health? _____

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 whiter
- Make them straighter
- Close spaces
- Replace black metal fillings with tooth colored restorations
- 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

-Where do you want your dental health to be?

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 dental visit today? _____

MEDICAL HISTORY

Please check any of the following that apply to you:

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

Do you have any of the following drug allergies?

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Codeine |
| <input type="checkbox"/> Darvon | <input type="checkbox"/> Erythromycin |
| <input type="checkbox"/> Nitrous Oxide | <input type="checkbox"/> Valium |
| <input type="checkbox"/> Percodan | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Other |

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

Are you taking any medications? What?

Family Physician _____ **Phone Number** _____

Patient/Guardian Signature: _____ **Date:** _____

Doctor Signature: _____ **Assistant Initial:** _____