Dental History

Why have you come to the dentist today?_____

Previous Dentist:_____ Date of last visit:_____

Are you currently in pain? ☐ Yes ☐ No

Are you teeth sensitive to hot or cold? ☐ Yes ☐ No

Do you require antibiotics before dental treatments? ☐ Yes ☐ No

Would you like fresher breath? ☐ Yes ☐ No

Your current dental health is ☐ Good ☐ Fair ☐ Poor

Would you like whiter teeth? ☐ Yes ☐ No

Do you floss daily? ☐ Yes ☐ No Brush daily? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

Are you happy with the way your smile looks? ☐ 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