DENTAL HISTORY

Patient Name_____

Please check any of the following that apply to you currently:

- ☐ Sensitivity (hot, cold, sweet etc.)
- ☐ Tooth pain or discomfort when chewing
- ☐ Headaches, ear aches or neck pain
- ☐ Mouth ulcers or cold sores
- ☐ Jaw joint pain
- ☐ Broken tooth or fillings
- ☐ Grinding or clenching teeth
- ☐ Bleeding, swollen, or irritated gums
- ☐ Loose, tipped, or shifted teeth
- ☐ Bad breath or bad taste in your mouth

Other _____

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: _____

Why did you leave previous dentist? _____

Do you smoke or use chewing tobacco? How much? For how long? _____

If you could change your smile, you would:

- ☐ Make my teeth whiter
- ☐ Make my teeth straighter
- ☐ Close spaces
- ☐ Replace metal fillings with 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

What is the most important thing to you about your dental visit today?

_____

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

_____

MEDICAL HISTORY

Please check any of the following that apply to you:

- ☐ Allergies (seasonal)
- ☐ Anemia
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Excessive Bleeding
- ☐ Glaucoma
- ☐ Heart Conditions
- ☐ Heart Murmur
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Anxiety
- ☐ Depression
- ☐ Pacemaker
- ☐ Radiation (head/neck)
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Other (please list):

_____

_____

_____

For Women Only:

- ☐ Birth Control Pills
- ☐ Breast Feeding
- ☐ Pregnant

_____

Are you currently under a physician's care? ____ If yes, Name of Physician: _____ Phone: _____

Are you currently taking any medications? ____ If yes, for what? _____

What Medications are you currently taking? _____

Do you have any allergies to medications? ____ If Yes, to what? _____

Are you allergic to Latex or metals? _____ Any other allergies? _____

I certify that I have read and understand the above and that the information given is an accurate and truthful health history.

Signature (parent or Guardian) _____ Date: _____