Patient Name _____

Medical Alert _____

DENTAL HISTORY

Welcome! So that we may provide you with the best possible care please complete both sides of the medical/dental history form. All information is completely confidential.

What is the reason for your visit today? _____

Do you have any dental problems now? Yes No
If yes, please describe: _____

Date of last Dental Visit _____ last Dental Cleaning _____ last Full Mouth x-rays _____

What was done at your last dental visit? _____

Did any previous dentist recommend dental treatment that was never performed? Yes No

If yes, what type of work was it? _____

Why was this treatment never performed? _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Rotodent, Interplak, toothpick, etc.) _____

Are any of your teeth sensitive to:

Hot or cold? …….	Yes	No
Sweets? ……	Yes	No
Biting or Chewing? ……..	Yes	No
Noticed any mouth odors or bad tastes? ….	Yes	No
Do you frequently get cold sores, blisters or any other oral lesion? ……...	Yes	No
Do your gums bleed or hurt? …….	Yes	No
Have your parents experienced gum disease or tooth loss? ……	Yes	No
Have you noticed any loose teeth or change in your bite? ……	Yes	No
Does food tend to become caught between any teeth? ……..	Yes	No

If yes, where? _____

Do you:

Clench/grind teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly? …….	Yes	No
Hold foreign objects with your teeth (pencils, pipe, pins, nails, fingernails) ..	Yes	No
Mouth breathe while awake or asleep? …..	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke/chew tobacco? …….	Yes	No
Do you feel nervous about dental treatment?	Yes	No
Ever had an upsetting dental experience? ...	Yes	No

If so, please describe _____

_____

_____

Have you ever had:

Orthodontic Treatment? …….	Yes	No
Oral Surgery? …….	Yes	No
Periodontal Treatment? ……..	Yes	No
Your teeth ground or bite adjusted? ……...	Yes	No
A bite plate or mouth guard? ……...	Yes	No
A serious injury to the mouth or head? ……..	Yes	No

If so, please describe, including cause _____

_____

Have you experienced:

Clicking or popping of the jaw? …….	Yes	No
Pain? (joint, ear, side of face) …….	Yes	No
Difficulty in opening or closing the mouth? ……..	Yes	No
Difficulty chewing on either side of mouth? …….	Yes	No
Headaches, neck aches, or shoulder aches? ……...	Yes	No
Sore muscles (neck, shoulders)? ……	Yes	No

Please **Circle** the following dental values **most important** to you and **Underline** the **least important**:

Esthetics Comfort Longevity Function
Long-term cost effectiveness

Please Circle the most important feature(s) in your smile that you would like to change? Color Shape Alignment Length Gaps Gum display Nothing, I'm Happy
Other _____

Would you like your smile analyzed? …… Yes No
If yes, is there a spouse or significant other you want to include in our discussion? …….. Yes No

Is there anything else about having dental treatment that you would like us to know? Yes No
If yes, please describe _____

MEDICAL HISTORY

Patient Name	Health Alert	BP:

1. Have you been under the care of a medical doctor during the past 2 years? . . . Yes No
   If yes, for what? _____
   Physician's Name _____ Phone _____

2. Have you taken any medication/drugs during the past 2 years? . . . . . Yes No

3. Are you taking any medication, drugs, or pills now? . . . . . Yes No
   If yes, please list name and dosage: _____

4. Are you aware of having an allergic (or adverse reaction) to any medication or substance?
   If yes, please list:_____ . Yes No

5. Have you been a patient in the hospital during the past 5 years? . . . . . Yes No

6. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Tuberculosis……....Yes No	Cortisone Medicine……Yes No	Hepatitis A (infectious) B(serum)Yes No
Asthma……..Yes No	Swollen Ankles……Yes No	Venereal Disease……Yes No
Hay Fever……Yes No	Stroke……Yes No	ALD.S……...Yes No
Latex Sensitivity ……..Yes No	Diet (Special Restricted)…….Yes No	HIV Positive……Yes No
Allergies/Hives ……Yes No	Artificial Joints (hip, knee)……..Yes No	Cold Sores/Fever Blisters …..Yes No
Sinus Trouble ……..Yes No	Kidney Trouble……..Yes No	Blood Transfusion……Yes No
Heart(Surgery/Disease/Attack)..Yes No	Thyroid Problems……Yes No	Hemophilia……...Yes No
Chest Pain……Yes No	Ulcers……..Yes No	Sickle Cell Disease……..Yes No
Congenital Heart Disease……..Yes No	Diabetes……Yes No	Bruise Easily……Yes No
Heart Murmur……...Yes No	Glaucoma……Yes No	Liver Disease……...Yes No
High Blood Pressure……..…Yes No	Contact Lenses……Yes No	Yellow Jaundice……...Yes No
Mitral Valve Prolapse……...Yes No	Emphysema……Yes No	Neurological Disorders……...Yes No
Artificial Heart Valve……...Yes No	Chronic Cough……Yes No	Epilepsy or Seizures ……Yes No
Heart Pacemaker……Yes No	Radiation Therapy……...Yes No	Fainting or Dizzy Spells……Yes No
Rheumatic Fever……Yes No	Chemotherapy……..Yes No	Nervous/Anxious……..Yes No
Arthritis/Rheumatism ……Yes No	Tumors……..Yes No	Psychiatric (Psychological Care)Yes No

7. Do you use more than two pillows to sleep? . . . . . Yes No

8. Have you lost or gained more than 10 pounds in the last year? . . . . Yes No

9. Do you have or have you had any disease condition, or problem not listed above? Yes No
   If yes, please list: _____

10. **Women** Are you: Pregnant? Yes, _____Months No **Nursing** Yes No
    Taking birth control pills? Yes No

I understand the above information is necessary to provide me with dental care in a safe & efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have may permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1 1**/2%** finance charge will be added to any balance over 30 days In the event of default I (we) promise to pay legal interest on the indebtedness, together with such collection costs & reasonable attorney fees as may be required to effect collection of this note

Patient/Guardian Signature _____ Date _____

History Review

Doctor Signature Date