

Name _____

Birth date _____

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

- Sensitivity (hot, cold, sweet) •
- Tooth pain or discomfort when chewing •
- 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 or bad taste in your mouth •

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 _____

MEDICAL HISTORY

Please check any of the following that apply to you:

- Acid Reflux
- AIDS
- Allergies (Seasonal)
- Allergic to Latex
- Anemia
- Arthritis
- Artificial Heart Valve
- Artificial Joints
- Asthma
- Blood Disease
- Bruise Easily
- Cancer
- Chemotherapy
- Diabetes
- Dizziness
- Drug Addiction
- Emphysema
- Excessive Bleeding
- Fainting
- Glaucoma
- Heart Conditions
- Heart Lesions (Congenital)
- Heart Murmur
- Heart Surgery
- Hepatitis A
- Hepatitis B

Do you have any of the following drug allergies?

- Aspirin
- Darvon
- Nitrous Oxide
- Percodan
- Local Anesthetic
- Codeine
- Erythromycin
- Valium
- Penicillin
- Other

To the best of my knowledge, all the preceding answers are true and correct. If I ever have any change in my health or change in my medication, I will inform the dentist at the next appointment.

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 brighter •
- Make them straighter •
- Close spaces •
- Replace silver fillings with natural, 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

Why did you leave your previous dentist?

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

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

- Hepatitis C
- High Blood Pressure
- HIV Positive
- Jaundice
- Jaw Joint Pain
- Kidney Disease
- Liver Disease
- Low Blood Pressure
- Mitral Valve Prolapse
- Nervousness/Depression
- Pacemaker
- Phen Fen (1 month +)
- Pregnant Currently
- Prescription or OTC meds
- Radiation (head/neck)
- Respiratory Problems
- Rheumatic Fever
- Rheumatism
- Scarlet Fever
- Seizures
- Stomach Problems
- Stroke
- Thyroid Disease
- Tuberculosis
- Ulcers
- Venereal Diseases
- Other

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

Are you taking any medications? What?

Family Physician _____ Phone Number _____

Signature of Patient _____

Date _____

Signature of Dentist _____

Date _____