



## PATIENT'S DENTAL HEALTH

Why have you come to see us today? (e.g.: pain, checkup, etc.) \_\_\_\_\_

Previous Dentist \_\_\_\_\_ Phone # \_\_\_\_\_ Date of Last Cleaning \_\_\_\_\_

Reasons for changing Dentists: \_\_\_\_\_ Last Visit \_\_\_\_\_

Have you had any problems with past dental treatment? \_\_\_\_\_

Are you nervous about seeing a dentist? Yes! No! If yes, please tell us why: \_\_\_\_\_

How often do you brush? \_\_\_\_\_ Do you floss? Yes No How often? \_\_\_\_\_

When you see your smile in the mirror, do you like the way your teeth look? \_\_\_\_\_

If you had a magic wand, is there something about your smile you would like to change? \_\_\_\_\_

Please describe how you would like your teeth to look: \_\_\_\_\_

Should you require any restoration, how long would you like your restoration to last? \_\_\_\_\_

Do you have any black mercury fillings that show or concern you that you would like to change?  Yes  No

If you could easily whiten your teeth for a very reasonable investment, would you be interested?  Yes  No

Do you have any crowns or caps that don't match your natural teeth or that you are unhappy with?  Yes  No

Are you interested in information about freshening your breath?  Yes  No

Have you had a periodontal surgery and / or root planning?  Yes  No When? \_\_\_\_\_

(Please circle each.)

<p>Y N I clench my teeth during the day or while sleep.</p> <p>Y N My gums bleed while brushing or flossing.</p> <p>Y N I avoid brushing part of my mouth due to pain.</p> <p>Y N I am interested in having my teeth straightened</p>	<p>Y N My gums feel tender or swollen.</p> <p>Y N I have problems eating.</p> <p>Y N I have had facial or jaw injury.</p>
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## PATIENT'S MEDICAL HISTORY

I consider my health to be (Please check one):  Excellent  Good  Fair  Poor

Do you have or have you had any of the following? Please circle Y for yes or N for no.

<p>1. Y N Heart disease</p> <p>2. Y N Heart Murmur/ Mitral Valve Prolapse</p> <p>3. Y N Stroke</p> <p>4. Y N Congenital Heart Lesions</p> <p>5. Y N Rheumatic Fever</p> <p>6. Y N Abnormal Blood Pressure</p> <p>7. Y N Anemia</p> <p>8. Y N Prolonged Bleeding Disorder</p> <p>9. Y N Tuberculosis or Lung Disease</p> <p>10. Y N Asthma</p> <p>11. Y N Hay Fever</p> <p>12. Y N Sinus Trouble</p> <p>13. Y N Epilepsy/ Seizure</p> <p>14. Y N Ulcers</p> <p>15. Y N Implants/Artificial Joints: Hip-Knee _____ Other _____</p> <p>16. Y N I smoke or use chewing tobacco. If yes, how much per day? How many years?</p> <p>17. Y N I have consumed alcohol within the last 24 hours.</p> <p>18. Y N I usually take an antibiotic prior to dental treatment.</p> <p>19. Y N Have you ever taken Fen-Phen or Redux?</p> <p>20. Y N I have had major surgery. Year _____ Type of operation _____</p> <p>21. Y N Do you have any other medical problem or medical history NOT listed on this form?</p>	<p>22. Y N Liver Disease</p> <p>23. Y N Jaundice</p> <p>24. Y N Hepatitis Type _____</p> <p>25. Y N Diabetes</p> <p>26. Y N Excessive Urination and/or Thirst</p> <p>27. Y N Infectious Mononucleosis ("Mono")</p> <p>28. Y N Herpes</p> <p>29. Y N Arthritis</p> <p>30. Y N Sexually Transmitted/Veneral Diseases</p> <p>31. Y N Kidney Disease</p> <p>32. Y N Tumor or Malignancy</p> <p>33. Y N Cancer/Chemotherapy</p> <p>34. Y N Radiation/Therapy</p> <p>35. Y N History of Drug Addiction</p>	<p>36. Y N AIDS</p> <p>37. Y N Immune Suppressed Disorder</p> <p>38. Y N Hearing Loss</p> <p>39. Y N Fainting Spells</p> <p>40. Y N Glaucoma</p> <p>41. Y N History of Emotional or Nervous Disorders</p> <p><b>WOMEN:</b></p> <p>42. Y N Are you taking birth control medication?</p> <p>43. Y N Are you or could you be pregnant or nursing?</p>
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**Doctor Notes Only:**

<p style="text-align: center;"><b>Are you allergic to any of the following?</b> Please circle Y for yes or N for no.</p> <p>44. Y N Aspirin/Ibuprofen</p> <p>45. Y N Sulfa Drugs/Sulfites/Sulfides</p> <p>46. Y N Penicillin</p> <p>47. Y N Codeine</p> <p>48. Y N Latex, Metals, Plastics</p> <p>49. Y N Local Anesthetics (Novocaine)</p> <p>50. Y N Other Medications Which Ones? _____</p>	<p style="text-align: center;"><b>Please list all medications you are currently taking:</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Physician's Name _____ Phone _____</p> <p>Address _____ Fax _____</p>
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**In the event of an emergency, please contact:**

Name _____	Relationship _____	Phone _____
Name _____	Relationship _____	Phone _____

<p>Medical health reviewed by:</p> <p>X _____ / /</p> <p style="text-align: center;">Doctor's Signature Date</p>	<p>X _____ / /</p> <p style="text-align: center;">Patient's Signature Date</p> <p>X _____ / /</p> <p style="text-align: center;">If Patient is a Minor, Parent/Guardian Signature Date</p>
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