Patient Name: _____ Date: _____

Last First (Preferred Name)

Yes No

Have you ever had any other serious illness not checked on previous page? Discuss _____ ☐ ☐

_____

Do you wish to talk to the dentist privately about any problems? _____ ☐ ☐

Women (Pls. check): ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking birth control pills. Discuss _____ ☐ ☐

DENTAL HISTORY

Do you have a specific dental problem today? Describe _____ ☐ ☐

Do you have dental examinations on a routine basis? Last visit _____ ☐ ☐

Do you think you have active decay or gum disease? _____ ☐ ☐

Do you brush and floss on a routine basis? Discuss _____ ☐ ☐

Do you gums ever bleed? Discuss _____ ☐ ☐

Does food catch between your teeth? Any loose teeth? _____ ☐ ☐

Do you ever have clicking, popping, or discomfort in your jaw joint? Do you brux or grind? _____ ☐ ☐

Do you smoke or chew tobacco? Any sores or growths in your mouth? Discuss _____ ☐ ☐

Name of previous dentist (optional) _____ ☐ ☐

Date of last full mouth x-rays (16 small films or panoramic): _____ ☐ ☐

Have your past experiences in a dental office always been positive? _____ ☐ ☐

Do you like your smile? Why? _____ ☐ ☐

Do you wish your teeth were whiter?	☐ Yes	☐ No
Will you consider bleaching/teeth whitening?	☐ Yes	☐ No
Are your teeth all in alignment (straight)?	☐ Yes	☐ No
Will you consider braces/straightening it?	☐ Yes	☐ No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medicine changes, I shall inform the dentist and staff at the next appointment without fail.

X _____ Date: _____

Patient Signature (Parent or Guardian)

Reviewed By Doctor _____ Date: _____

REFERRAL INFORMATION

Whom may we thank for referring you our practice?

☐ another patient, friend/relative ☐ GSDBA ☐ Dental Office/Signage ☐ SBC/Flamingo Yellow Pages

☐ Newspaper (GLT) ☐ Insurance Company ☐ Website/Internet Search ☐ Other _____

Name of person or office referring you to our practice _____

MEDICAL UPDATES *(yearly)*

I have read my MEDICAL HISTORY and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	BP	REVIEWED BY
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____
_____	_____	None ☐	_____	_____	Dr. _____

History Review and Significant Findings _____