

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last First (Preferred Name)

Have you ever had any other serious illness not checked on previous page? Discuss \_\_\_\_\_ Yes No

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 your 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 <input type="checkbox"/> _____	_____	Dr. _____
_____	_____	None <input type="checkbox"/> _____	_____	Dr. _____
_____	_____	None <input type="checkbox"/> _____	_____	Dr. _____
_____	_____	None <input type="checkbox"/> _____	_____	Dr. _____
_____	_____	None <input type="checkbox"/> _____	_____	Dr. _____

History Review and Significant Findings \_\_\_\_\_