



Patient's Name _____
Last First Initial Date of Birth

COMMENTS

1. Purpose of your initial visit _____
2. Are you aware of any problem?.....YES NO
3. How long has it been since your last dental visit? _____
4. What was done at that time? _____
5. What is your previous dentist's name? _____
Address _____ Telephone _____
6. When was the last time your teeth were cleaned? _____

CIRCLE THE APPROPRIATE ANSWER. IF YOU DO NOT KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" AFTER THE QUESTION.

7. Have you made regular dental hygiene visits?.....YES NO
How often: _____
8. Were any dental x-rays taken?YES NO
9. Have you lost any teeth or have any teeth been removed?YES NO
10. Have they been replaced?.....YES NO
11. How have they been replaced?
Fixed Bridge _____ Approximate age of bridge _____
Partial Denture _____ Approximate age of partial _____
Denture _____ Approximate age of denture _____
Dental Implant _____ Approximate age of implant _____
12. Are you unhappy with the replacement?YES NO
If yes, explain _____
13. Would you like to know about permanent replacements? YES NO
14. Have you ever had any complications with any previous dental care? YES NO
15. Do you clench or grind your teeth that you are aware of? YES NO
16. Does your jaw ever click or pop? YES NO
17. Have you ever experienced any pain or soreness in the muscles or your face around your ear? YES NO
18. Do you have frequent headaches, neck aches or shoulder aches? YES NO
19. Does food get caught in your teeth? YES NO
20. Are any of your teeth sensitive to: ___Hot ___Cold ___Sweets ___Pressure
21. Do your gums bleed or hurt? YES NO
If yes, when? _____
22. Do you experience dry mouth? YES NO
23. How often do you brush your teeth? _____ When? _____
24. How often do you floss your teeth? _____ When? _____
25. Are any of your teeth loose, tipped, shifter or chipped? YES NO
26. Are you unhappy with the appearance of your teeth? YES NO
27. How do you feel about your teeth in general? _____
28. Do you feel your breath is ever offensive? _____
29. Have you ever had gum surgery? _____ If yes, indicate when, where, and what type of gum surgery you had. _____
30. Have you ever had orthodontic work (braces)?YES NO
31. Have you had any unpleasant dental experiences? YES NO
If yes, please explain _____
32. Do you have questions or concerns to talk to the doctor or hygienist about?... YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MEDICAL ALLERTS

DENTAL HISTORY



CIRCLE THE APPROPRIATE ANSWER, IF UNSURE OF CORRECT ANSWER, WRITE "DON'T KNOW" ON THE DOTTED LINE

COMMENTS

1. Physician's Name _____ Phone _____
2. Address _____ FAX _____
3. Are you under a physician's care?.....YES NO
4. Why? _____ Since when _____
5. When was your last complete physical exam? _____
6. Are you taking any medications or substances?.....YES NO
(If yes, please list medications in the comment section or on the back)
7. Do you routinely take health related substances?.....YES NO
(Vitamins, herbal supplements, natural products non prescription)
8. Are you allergic to any medications or substances?YES NO
If yes, please list _____
9. Do you have any other allergies or hives?.....YES NO
10. Do you have problems taking penicillin, antibiotics, anesthetics or any other medications?.....YES NO
11. Are you sensitive to any metals or latex?.....YES NO
12. Are you pregnant or suspect you may be?.....YES NO
13. Do you use birth control medications?.....YES NO
14. Have you ever been treated for or have been told that you might have heart disease?YES NO
15. Do you have a pacemaker, an artificial heart valve implant, or been diagnosed with mitral valve prolapse?.....YES NO
16. Have you ever had rheumatic fever?.....YES NO
17. Are you aware of any heart murmurs?.....YES NO
18. Do you have high or low blood pressure?(please circle)YES NO
19. Have you ever had a serious illness or major surgery?.....YES NO
If so, please explain _____
20. Have you ever had radiation treatment, chemo treatment for tumor, growth or other condition? ...YES NO
21. Have you ever taken Fosamax, Zometa, Aredia or any oral intravenous treatment (bisphosphonates) for bone tumors, excessive calcium in your blood or osteoporosis?.....YES NO
22. Do you have any artificial joints/prosthesis?.....YES NO
23. Do you have any blood disorders, such as anemia, leukemia?.....YES NO
24. Have you ever bled excessively after being cut or injured?.....YES NO
25. Do you have any stomach problems?.....YES NO
26. Do you have kidney problems?.....YES NO
27. Do you have liver problems?.....YES NO
28. Are you diabetic?.....YES NO
29. Do you have fainting or dizzy spells?.....YES NO
30. Do you have asthma?.....YES NO
31. Do you have epilepsy or seizure disorders?.....YES NO
32. Do you or have you had venereal or any sexually transmitted disease?.....YES NO
33. Have you been tested for HIV positive?.....YES NO
34. Do you have AIDS?.....YES NO
35. Have you had or do you test positive for hepatitis?.....YES NO
36. Do you or have you had T.B.?.....YES NO
37. Do you smoke, chew, use snuff or any other forms of tobacco?.....YES NO
38. Do you regularly consume more than one or two alcoholic beverages a day?.....YES NO
39. Do you habitually use controlled substances?.....YES NO
40. Have you had psychiatric treatment?.....YES NO
41. Have you taken any prescription drugs fenfluramine, fenfluramine combined with phentermine (fen-phen) dexfenfluramine (redux), or other weight loss products?.....YES NO
42. Do you have any disease condition, or problem not listed? If so, explain _____
43. Is there anything else we should know about your health that we have not covered in this form?..YES NO
44. Would you like to speak to the Doctor privately about any problem?.....YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

ANEST.

MED. ALERT

MEDICAL HISTORY