DENTAL HISTORY

What is the nature of today's visit? ☐ Exam ☐ Consultation ☐ Emergency _____

Former Dentist _____ Phone _____ City _____

Date of last dental care _____ Date of last x-rays _____

Please check any of the following that apply to you:

☐ Bad breath	☐ Bleeding gums	☐ Clicking / popping of the jaw	☐ Trapping food between teeth
☐ Grinding teeth	☐ Loose teeth or broken fillings	☐ Periodontal treatment	☐ Sensitivity to cold
☐ Sensitivity to sweets	☐ Sensitivity when biting	☐ Sores or growths in mouth	☐ Sensitivity to hot

How often do you brush? _____ How often do you floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a dental procedure? _____

Other information about your dental health or previous treatment? _____

MEDICAL HISTORY

Physician's Name _____ City _____ Phone _____

Date of last visit _____ Have you had any serious illnesses or operations? ☐ Yes ☐ No

If yes, describe _____

Are you currently under physician care? ☐ Yes ☐ No If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate date _____

Have you ever taken Fen-Phen / Redux? ☐ Yes ☐ No Have you ever taken osteoporosis medications? ☐ Yes ☐ No

Women: Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Using birth control medication? ☐ Yes ☐ No

Check ☑ if you have had any of the following:

- ☐ AIDS/HIV positive
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Arthritis, rheumatism
- ☐ Artificial heart valve
- ☐ Artificial joints
- ☐ Asthma
- ☐ Atopic (allergy prone)
- ☐ Back problem
- ☐ Blood disease
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Chemotherapy
- ☐ Circulatory problems
- ☐ Cortisone treatments
- ☐ Cough, persistent
- ☐ Cough up blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Food allergies
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart murmur
- ☐ Heart problems describe _____
- ☐ Hemophilia/abnormal bleeding
- ☐ Herpes
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Jaw pain
- ☐ Kidney problem
- ☐ Liver disease
- ☐ Material allergies (latex, wool, metal, chemicals)
- ☐ Mitral valve prolapse
- ☐ Nervous problems
- ☐ Pacemaker/ heart surgery
- ☐ Psychiatric care
- ☐ Rapid weight gain/loss
- ☐ Radiation treatment
- ☐ Respiratory disease
- ☐ Rheumatic/scarlet fever
- ☐ Shingles
- ☐ Shortness of breath
- ☐ Skin rash
- ☐ Spina Bifida
- ☐ Surgical Implant
- ☐ Swelling of feet or ankles
- ☐ Thyroid disease/ malfunction
- ☐ Tobacco habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer/Colitis
- ☐ Venereal disease

Is patient currently taking any medications? If Yes, list all:

_____

_____

Does patient have any drug allergies? If yes, list all:

_____

_____

AUTHORIZATION

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my dentist if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

I have received copies of the Dental Materials Facts Sheet and HIPAA Privacy Practices _____