Dental History

Are you aware of any dental problems? If so, please explain: _____
_____

Name of your previous dentist _____
When was your last dental cleaning? _____
When was your last set of complete x-rays? _____
If you have incomplete dental treatment from your prior dentist, what prevented you from receiving it?
☐ **Time** ☐ **Cost** ☐ **Fear** ☐ **Other:** _____
Why did you decide to leave your previous dentist? _____

Please check any of the following problems that may apply to you:

- ☐ Sensitivity (hot, cold, sweets)
- ☐ Tooth pain when chewing
- ☐ Teeth or fillings breaking
- ☐ Jaw Joint Pain
- ☐ Grinding / clenching teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, tipped or shifting teeth
- ☐ Missing teeth
- ☐ Bad breath or bad taste in your mouth
- ☐ Dry mouth

Please indicate current / past dental treatments:

- ☐ Dentures / partial dentures
- ☐ Dental implants
- ☐ Wear a night-guard
- ☐ Adult teeth extracted
- ☐ Braces
- ☐ Treatment for TMJ
- ☐ Deep Cleanings / periodontal treatment

If you could change anything about your smile would it be?

- ☐ Make them brighter
- ☐ Close spaces
- ☐ Repair chipped teeth
- ☐ Alternative to a denture
- ☐ Get a smile makeover
- ☐ Make them straighter
- ☐ Replace metal fillings with tooth colored ones
- ☐ Replace missing teeth
- ☐ Replace old crowns that don't match

What is the most important thing about your dental visit today? _____
On a scale of 1-10, with 10 being the highest:

How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

How would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

Medical History

Please circle "**Y**" for Yes and "**N**" for No of any of the following that APPLIES TO THE PATIENT:

Y N Aids / HIV +	**Y N** Anemia	**Y N** Arthritis	**Y N** Artificial joints	**Y N** Artificial heart valve
Y N Seasonal allergies	**Y N** Asthma	**Y N** Blood disease	**Y N** Bruise easily	**Y N** Cancer
Y N Chemotherapy	**Y N** Diabetes	**Y N** Dizziness	**Y N** Drug addiction	**Y N** Emphysema
Y N Excessive Bleeding	**Y N** Fainting	**Y N** Glaucoma	**Y N** Heart condition	**Y N** Heart murmur
Y N Hepatitis A / B / C	**Y N** High blood pressure	**Y N** Low blood pressure	**Y N** Jaundice	**Y N** Kidney disease
Y N Mitral valve prolapse	**Y N** Anxiety / Depression	**Y N** Pacemaker	**Y N** Osteoporosis	**Y N** Radiation
Y N Respiratory illness	**Y N** Rheumatic fever	**Y N** Rheumatism	**Y N** Seizures	**Y N** Stomach problems
Y N Stroke	**Y N** Thyroid disease	**Y N** Currently pregnant?	**Y N** Liver disease	**Y N** Latex allergy
Y N Allergies to antibiotics	**Y N** Tuberculosis	**Y N** Boniva / Fosimax	**Y N** Hormone replacement therapy	

Do you smoke or use chewing tobacco? ☐ **YES** ☐ **NO** **How much?** _____ **How long?** _____

What medical conditions are you currently being treated for? _____

Physicians name: _____ **Phone #:** _____

Please list any medications you are currently taking: _____

Please list any medications you are allergic to or have bad reactions to: _____

To the best of my knowledge, I have answered every question completely and accurately. It is my responsibility to inform Dr.'s Tsibel and Abaro of any changes in my health and or medications.

Patient's signature: _____ **Date:** _____ A) **Reviewed by:** _____

B) Reviewed by: _____ Date: _____ C) Reviewed by: _____ Date: _____ D) Reviewed by: _____ Date: _____