Patient Dental History

Name of Previous Dentist _____ *Phone:* _____ *Date of Last Exam:* _____

Address: _____

	YES	NO
1. *Do your gums bleed while brushing or flossing?*	❒	❒
2. *Are your teeth sensitive to hot or cold liquids/foods?*	❒	❒
3. *Are your teeth sensitive to sweet or sour liquids/foods*	❒	❒
4. *Do you feel pain to any of your teeth?*	❒	❒
5. *Do you have any sores or lumps in or near your mouth?*	❒	❒
6. *Have you had any head, neck or jaw injuries?*	❒	❒
7. *Have you ever experienced any of the following problems in your jaw?*		
Clicking	❒	❒
Pain (joint, ear, side of face)	❒	❒
Difficulty in opening or closing	❒	❒
Difficulty in chewing	❒	❒
8. *Do you have frequent headaches?*	❒	❒
9. *Do you clench or grind your teeth?*	❒	❒
10. *Do you bite your lip or cheeks frequently?*	❒	❒
11. *Have you ever had any difficult extractions in the past?*	❒	❒
12. *Have you ever had any prolonged bleeding following extractions*	❒	❒
13. *Have you had any orthodontic treatment?*	❒	❒
14. *Do you wear dentures or partials?*	❒	❒
If yes, date of placement _____		
15. *Have you ever received oral hygiene instructions regarding the care of your teeth and gums?*	❒	❒
16. *Do you like your smile?*	❒	❒

Medical Updates

Date: _____ *Pulse:* _____ *BP:* _____

DATE	EXCEPTIONS

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

X _____

Signature of patient (or parent/guardian if minor) *Date*

Doctor's Comments: _____

Signature: _____ *Date:* _____

Patient Medical History

	YES	NO
1. Are you under medical treatment now?	❒	❒
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	❒	❒
If yes, please explain: _____		
_____		
3. Are you taking any medication(s) including non-prescription medicine?	❒	❒
If yes, **LIST ALL** medication(s) are you taking? _____		
_____		

Physician: _____

Office Phone: _____

Date of Last Exam: _____

Address: _____

4. Are you taking any of the following:		
Anticoagulants (Blood Thinners)	❒	❒
Blood Pressure Medication	❒	❒
Cortisone (Steroids)	❒	❒
Tranquilizers	❒	❒
Insulin	❒	❒
Heart Drugs, Nitroglycerin	❒	❒

	YES	NO
6. Have you ever taken Fen-Phen/Redux/Fosamax?	❒	❒
7. Do you use tobacco products?	❒	❒
8. Do you use controlled substances?	❒	❒
9. Are you wearing contact lenses?	❒	❒
10. Are you allergic to or have you had any reactions to the following?		
Local Anesthetics (e.g. Novocain)	❒	❒
Penicillin or any other Antibiotics	❒	❒
Sulfa Drugs	❒	❒
Barbiturates	❒	❒
Sedatives	❒	❒
Iodine	❒	❒
Aspirin / Codeine	❒	❒
Any Metals (e.g. nickel, mercury, etc.)	❒	❒
Latex Rubber	❒	❒
Other (please list)_____	❒	❒
11. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)	❒	❒
12. Women Only:		
a) Are you pregnant or think you may be pregnant?	❒	❒
b) Are you nursing?	❒	❒
c) Are you taking oral contraceptives?	❒	❒

5. Do you have or have you had any of the following?

	YES	NO
High Blood Pressure	❒	❒
Low Blood Pressure	❒	❒
Heart Attack	❒	❒
Rheumatic Fever/Scarlet Fever	❒	❒
Swollen Ankles	❒	❒
Fainting / Seizures	❒	❒
Asthma	❒	❒
Epilepsy / Convulsions	❒	❒
Leukemia	❒	❒
Diabetes	❒	❒
Kidney Diseases	❒	❒
AIDS or HIV Infection	❒	❒
Thyroid Problem	❒	❒
Heart Disease / Surgery	❒	❒
Cardiac Pacemaker	❒	❒
Heart Murmur	❒	❒
Angina	❒	❒
Frequently Tired	❒	❒
Anemia	❒	❒
Emphysema	❒	❒
Cancer / Previous Cancer	❒	❒
Arthritis	❒	❒
Joint Replacement or Implant	❒	❒
Hepatitis A or B	❒	❒
Sexually Transmitted Disease	❒	❒
Stomach Troubles / Ulcers	❒	❒
Excessive Thirst	❒	❒
Jaundice	❒	❒

	YES	NO
Hemophilia	❒	❒
Chest Pains	❒	❒
Cold Sores / Fever Blisters / Herpes	❒	❒
Stroke	❒	❒
Hay Fever / Allergies	❒	❒
Tuberculosis	❒	❒
Radiation / Chemotherapy	❒	❒
Glaucoma	❒	❒
Recent Weight Loss	❒	❒
Liver Disease	❒	❒
Heart Trouble	❒	❒
Respiratory Problems	❒	❒
Mitral Valve Prolapse	❒	❒
Blood Disease	❒	❒
Congenital Heart Lesion	❒	❒
Artificial Heart Value	❒	❒
Nervousness	❒	❒
Alzheimer's Disease	❒	❒
Hypoglycemia	❒	❒
Psychiatric Care	❒	❒
Drug Addiction	❒	❒
Blood Transfusion	❒	❒
Bruise Easily	❒	❒
Sickle Cell Anemia	❒	❒
Lung Disease	❒	❒
Sinus Trouble	❒	❒
Rheumatism	❒	❒
Other _____	❒	❒