DENTAL HISTORY

PATIENT NAME_____ BIRTHDATE _____
Reason for Today's Visit _____
Date of last dental care _____Former Dentist _____
Date of last dental X-Rays _____

Are you satisfied with your smile? Yes No If not, do you want to improve it? Yes No
Are you interested in using sedation for your appointments? Yes No

Check (☐) if you have had problems with the following:

☐ Bad breath ☐ Grinding ☐ Teeth Sensitivity to hot ☐ Reaction to local
☐ Bleeding gums ☐ Loose teeth or broken fillings ☐ Sensitivity to sweets Anesthetic
☐ Clicking or popping jaw ☐ Periodontal Treatment ☐ Sensitivity when biting
☐ Food collection between teeth ☐ Sensitivity to cold ☐ Sores or growths in mouth

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

MEDICAL HISTORY

Physician's Name _____ Phone Number _____
Have you had any serious illnesses or operations? _____ If yes, please describe:
_____
Have you ever had a blood transfusion? Yes No If yes, give approx dates_____

(Women) Are you pregnant? Yes No Nursing? Yes No

Please **circle** Yes or No if you have or have had any of the following:

Anemia or Blood Disorder?	Yes	No	Hepatitis, Any Form	Yes	No
Arthritis or Rheumatism	Yes	No	Joint Replacement	Yes	No
Asthma	Yes	No	Kidney Disease	Yes	No
Cancer	Yes	No	Liver Disease	Yes	No
Diabetes	Yes	No	Psychosis	Yes	No
Respiratory/Lung Illness	Yes	No	Previous Biopsies	Yes	No
Epilepsy	Yes	No	Radiation or Chemotherapy	Yes	No
Glaucoma	Yes	No	Rheumatic Fever	Yes	No
Heart Valve (artificial)	Yes	No	H.I.V/Aids or ARC	Yes	No
Heart Disease or Heart Attack	Yes	No	Osteoporosis/Biophosphates	Yes	No
High Blood Pressure	Yes	No	Other:		

Please list any Medications you are taking, and for what purpose:

_____

_____

Do you use tobacco? If yes, circle type: smoke chew How much per day? _____
Do you consume Alcohol? If yes, approximately how many alcoholic beverages per week? _____

Are you allergic to?

Local anesthetics	Yes	No	Codeine, Valium, or other sedatives	Yes	No
Penicillin or other antibiotics	Yes	No	Latex or Metals	Yes	No
Aspirin, Ibuprofen, or Tylenol	Yes	No	Other (please specify)		

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of knowledge.

_____ _____
Patient/Guardian Signature Date

Office Use:

_____ _____ _____ _____
ASA Assistant lbs (if child) Date