PATIENT DENTAL HISTORY:

Name of previous dentist _____ City _____ State _____ Phone Number _____

1. Please check any of the following problems that apply to you.

	Yes	No
Sensitivity/Pain (e.g. hot, cold, sweet, pressure)	☐	☐
Where? UR LR UL LL		
Headaches, earaches, neck pain	☐	☐
Jaw joint pain	☐	☐
Teeth or fillings breaking	☐	☐
Grinding or clenching teeth	☐	☐
Difficulty in chewing	☐	☐
Bleeding, swollen or irritated gums	☐	☐
Difficulty in opening/closing	☐	☐
Loose, tipped or shifting teeth	☐	☐
Bad breath	☐	☐
2. Do you have or have you had any of the following?	☐	☐
Dentures	☐	☐
Partial dentures	☐	☐
Braces	☐	☐
Periodontal (gum) treatments	☐	☐
Any sores or lumps in or near your mouth	☐	☐
Any diffcult extractions in the past	☐	☐
Any prolonged bleeding following extractions	☐	☐
3. Do you smoke, vape or use chewing tobacco?	☐	☐

How much? _____ *How long?* _____

4. Please share the following dates:
   - *-Your last cleaning* ____ /____
   - *-Your last oral cancer screening* ____ /____
   - *-Your last complete X-rays* ____ /____

5. If I could change my smile, I would:	Yes	No
Make it whiter	☐	☐
Make it straighter	☐	☐
Close spaces	☐	☐
Make teeth longer	☐	☐
Change the shape of the teeth	☐	☐
Replace black metal fillings with tooth colored restorations	☐	☐
Repair chipped teeth	☐	☐
Replace missing teeth	☐	☐
Replace old crowns that don't match	☐	☐
Have a smile makeover	☐	☐

6. On a scale of 1-10, with 10 being the highest rating:
   - *How important is your dental health to you?*
     1 2 3 4 5 6 7 8 9 10
   - *Where would you rate your current dental health?*
     1 2 3 4 5 6 7 8 9 10
   - *Where do you want your dental health to be?*
     1 2 3 4 5 6 7 8 9 10

7. *Why did you leave your previous dentist?*
   _____

What is the most important thing to you about your future smile and dental health? _____

What is the most important thing to you about your dental visit today? _____

PATIENT MEDICAL HISTORY:

Name of family physician _____ City _____ State _____ Phone Number _____

1. Please check any of the following problems/conditions that apply to you:

	Yes	No		Yes	No		Yes	No		Yes	No
AIDS	☐	☐	Diabetes	☐	☐	High blood pressure	☐	☐	Respiratory problems	☐	☐
Allergies (seasonal)	☐	☐	Dizziness	☐	☐	HIV positive	☐	☐	Rheumatic fever	☐	☐
Anemia	☐	☐	Drug addiction	☐	☐	HPV (human papilloma virus)	☐	☐	Rheumatism	☐	☐
Angina (chest pain)	☐	☐	Emphysema	☐	☐	Jaundice	☐	☐	Scarlet fever	☐	☐
Arthritis	☐	☐	Epilepsy	☐	☐	Jaw joint pain	☐	☐	Seizures	☐	☐
Artificial heart valve	☐	☐	Excessive bleeding	☐	☐	Kidney disease	☐	☐	Sinus problems	☐	☐
Artificial joints	☐	☐	Fainting	☐	☐	Liver disease	☐	☐	Sleep apnea	☐	☐
Asthma	☐	☐	Glaucoma	☐	☐	Low blood pressure	☐	☐	Stomach problems	☐	☐
Blood disease	☐	☐	Heart conditions	☐	☐	Mitral valve prolapse	☐	☐	Stroke	☐	☐
Breastfeeding (currently)	☐	☐	Heart lesions (congenital)	☐	☐	Nervousness/depression	☐	☐	Thyroid disease	☐	☐
Bruise easily	☐	☐	Heart murmur	☐	☐	Osteoporosis	☐	☐	Tuberculosis	☐	☐
Cancer	☐	☐	Heart surgery	☐	☐	Pacemaker	☐	☐	Ulcers	☐	☐
Cervical cancer	☐	☐	Hepatitis A	☐	☐	Pregnant (currently)	☐	☐	Venereal diseases	☐	☐
Chemotherapy	☐	☐	Hepatitis B	☐	☐	Radiation (head/neck)	☐	☐	Other _____		
Cortisone medication	☐	☐	Hepatitis C	☐	☐	Reflux	☐	☐	_____		

2. Are you allergic or have you reacted adversely to any of the following medications?

	Yes	No		Yes	No		Yes	No		Yes	No
Aspirin	☐	☐	Hydrocodone	☐	☐	Penicillin	☐	☐	Valium	☐	☐
Clindamycin	☐	☐	Latex	☐	☐	Percodan	☐	☐	Any metals (nickel, mercury, etc.)	☐	☐
Codeine	☐	☐	Local Anesthetic	☐	☐	Sulfa	☐	☐	Other _____		
Halcion	☐	☐	Nitrous Oxide	☐	☐	Tetracycline	☐	☐	_____		

3. Have you ever taken any of the following medications for osteoporsis?

	Yes	No		Yes	No
Actonel	☐	☐	Herbal Supplements	☐	☐
Aredia	☐	☐	Reclast	☐	☐
Boniva	☐	☐	Zometa	☐	☐
Fosamax	☐	☐	Other _____		

Are you under a physician's care? What for?

_____

What medications are you currently taking?

_____

_____

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.

_____ _____ _____

Patient Signature (parent if child) *Date* *Witness Signature*