Dental History

Name: ______ **Today's Date:** ______

The reason for you visit today is: ______

The date you last visited a dentist was ______ Last dental cleaning was on ______

How often do you normally have dental check ups and cleanings? ______

Your previous Dentist's information:

Name ______ Phone ______

Address ______ State ______ Zip ______

Please tell us why, if you are changing dentists ______

Please check (✓) the appropriate answer for each of the following: (Please answer yes or no for each item)

YES NO **Do You:**

- O ☐ Have bad tastes or mouth odor frequently?
- O ☐ Frequently get cold sores, blisters, or other oral lesions?
- O ☐ Have sore or bleeding gums?
- O ☐ Have any loose teeth or changes in your bite?
- O ☐ Frequently get food caught between your teeth? Where? ______
- O ☐ Have parents who have experienced gum disease or tooth loss?
- O ☐ Clinch or grind teeth while awake or asleep?
- O ☐ Bite your lips or cheeks regularly?
- O ☐ Hold objects with you teeth (pencils, pens, nails)?
- O ☐ Mouth breathe while asleep/awake?
- O ☐ Use two pillows when sleeping?

In the last 6 months have you experienced:

- O ☐ Clicking or popping of the jaw?
- O ☐ Pain (joint, ear, side of face)?
- O ☐ Difficulty in opening or closing your mouth?
- O ☐ Difficulty chewing on either side of your mouth?
- O ☐ Head, neck, or shoulder aches?
- O ☐ Tired jaws, especially in the morning?

YES NO **Are any of your teeth sensitive to:**

- O ☐ Hot or Cold
- O ☐ Sweets
- O ☐ Biting/chewing

Have you had any of the following:

- O ☐ Oral Surgery
- O ☐ Periodontal Treatment
- O ☐ A serious injury to your head or mouth
- O ☐ Orthodontic treatment (Braces or removable appliances)
- O ☐ Your teeth ground down or adjusted
- O ☐ A bite plate or mouth guard

Are you nervous about having dental treatment?
O Yes ☐ No

If you have ever had an upsetting dental visit please describe ______

______

If you answered **yes** to **any** of the above please describe ______

______

______

Are you satisfied with the way your teeth look?
O Yes ☐ No

Would you like to keep **your** teeth all of your life?
O Yes ☐ No

The information on both sides of this form is true to the best of my knowledge. If further information is needed I give this office my permission to contact the respective health care providers to release such information. I hereby authorize the Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorough diagnosis of my dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated. I further authorize and consent that the Doctor choose and employ such assistance deemed fit. **I understand it is my responsibility to notify the doctor of any changes in my health or medication on an ongoing basis.**

Patient Signature ______ Date ______

If patient is a minor Parent?Guardian Signature

Health History

So that we may provide you with comprehensive and safe dental care, please complete the following necessary information.

All information is kept confidential.

Your Name:______________________________ Today's Date______________________

Physician's Name:____________________________ Phone No.____________________

Are you seeing any other doctors? ☐ No ○ Yes If yes please list their name and the reason you see them______________________________

Are you taking any medication, drugs or pills now? ☐ No ○ Yes If yes please list name(s) and dosage(s)______________________________

Have you taken any medication, drugs or pills in the last two years? ☐ No ○ Yes If yes please list them______________________________

Are you aware of having any allergic or adverse reaction to any medication or substance? ☐ No ○ Yes If yes please list the medication or substance and the reaction______________________________

____

Have you been a patient in a hospital in the last five years? ☐ No ○ Yes If yes please list the reason for the hospitalization______________________________

Have you ever had a complete physical exam? ☐ No ○ Yes Most recent exam was on__________

Please check (✓) any of the following you have or have had in the past year.

(Please answer yes or no for each item)

YES	NO		YES	NO		YES	NO	
○	☐	Bruise easily	○	☐	Diabetes	○	☐	Arthritis/Rheumatism
○	☐	Fainting	○	☐	Thyroid Problems	○	☐	Ulcers
○	☐	Dizziness	○	☐	Glaucoma	○	☐	Chemotherapy
○	☐	Nervousness	○	☐	Contact Lenses	○	☐	Tumors
○	☐	Depression	○	☐	Emphysema	○	☐	Hepatitis A (infectious)
○	☐	Headaches	○	☐	Tuberculosis	○	☐	Hepatitis B (serum)
○	☐	Sinus trouble	○	☐	Asthma	○	☐	A.I.D.S.
○	☐	Cold Sores	○	☐	Hay Fever	○	☐	H.I.V. Positive
○	☐	Anxiety	○	☐	Latex Sensitivity	○	☐	Blood transfusion
○	☐	Fever Blisters	○	☐	Allergies/Hives	○	☐	Hemophelia
○	☐	Blurred Vision	○	☐	Radiation Therapy	○	☐	Sickle Cell Disease
○	☐	Earaches	○	☐	Psychiatric/Psychological Care	○	☐	Liver Disease
○	☐	Chronic cough				○	☐	Yellow Jaundice
○	☐	Kidney trouble	○	☐	Hearth Attack/Disease	○	☐	Neurological Disorders
○	☐	Nosebleeds	○	☐	Heart Surgery	○	☐	Epilepsy/Seizures
○	☐	Weight loss/gain (More than 10 lbs. in 1 yr.)	○	☐	Congenital Heart Disease	○	☐	Cortisone Medicine
			○	☐	Heart Murmur	○	☐	Stroke
○	☐	High Blood Pressure	○	☐	Mitral Valve Prolapse	○	☐	Diet (Special/Restricted)
○	☐	Swollen Ankles	○	☐	Artificial Heart Valve	○	☐	Artificial Joints (Hip, Knee, etc.)
○	☐	Chest Pain	○	☐	Rheumatic Fever			
○	☐	Low Blood Pressure	○	☐	Sleep Apnea	○	☐	Acid Reflux
○	☐	Poor Circulation						

Do you have any disease, condition or symptoms not listed above? ☐ No ○ Yes

If yes, please describe______________________________

Women Only:

Are you *taking birth control pills?* ☐ No ○ Yes

Are you *pregnant?* ☐ No ○ Yes How many months? ______

Are you *nursing?* ☐ No ○ Yes

Please continue on the other side