

Happy Smiles

Health and Dental History

Today's Date: _____ Appointment Date: _____ Time: _____

Patient Name: _____ Nickname: _____ Birth Date: _____
Last First MI

Parent/Guardian (if applicable): _____ Patient Age: _____
____ Male ____ Female ____ Married ____ Single ____ Child ____ Other

Phone Numbers:

Home: _____ Work: _____ Cell: _____

Email Address: _____

Address: _____
Street Apartment #

City: _____ State: _____ Zip: _____ SSN# _____

Health Information

Date of Last Dental Visit: _____ Reason for Visit: _____

Are You Currently in Any Dental Pain Right Now? Yes No
If yes, Please explain _____

Have You Ever Had Any Complications During or Following Dental Treatment? Yes No
If Yes, Please Explain: _____

Are You Unhappy About Your Smile? Yes No
If Yes, Please Explain: _____

Have You Had Braces? Yes No
If Yes, Please List Orthodontist's Name and Number: _____

Are You Aware of Having an Allergic Reaction to Any Medication or Substance? Yes No
If Yes, Please Explain: _____

Do You Smoke or Drink? Yes No
If Yes, Please Explain: _____

Are You Taking/Using any Recreational Drugs? Yes No
If Yes, Please Explain: _____

Are you Pregnant, Nursing, or Trying to Become Pregnant? Yes No
If Yes, When is Your Due Date: _____

Are You Taking Birth Control Pills? Yes No
If Yes, Please Provide Name: _____

Have You Been Admitted to the Hospital or Needed Emergency Care During The Past Two Years? Yes No
If Yes, Please Explain: _____

Are You now Under The Care of a Physician? Yes No
If Yes, Please Explain: _____

Are You Taking Any Medications? Yes No
If Yes, Please List Name And Dose: _____

HAVE YOU EVER EXPERIENCED OR HAD ANY OF THE FOLLOWING? PLEASE CIRCLE YES OR NO TO EACH ITEM.

AIDS/HIV	Yes	No	Grinding of Teeth	Yes	No	Prosthetic Heart Valve	Yes	No
Allergies	Yes	No	Growths	Yes	No	Radiation Treatment	Yes	No
Anemia	Yes	No	Hay Fever	Yes	No	Respiratory Problems	Yes	No
Arthritis/Rheumatism	Yes	No	Hardening of the Arteries	Yes	No	Rheumatic Fever	Yes	No
Artificial Joints	Yes	No	Headaches	Yes	No	ringing of Ears	Yes	No
Artificial Heart Valve	Yes	No	Head Injuries	Yes	No	Sensitive Teeth	Yes	No
Asthma	Yes	No	Heart Attack	Yes	No	Sexually Transmitted Disease	Yes	No
Bell's Palsy	Yes	No	Heart Disease	Yes	No	Shortness of Breath	Yes	No
Bladder Disease/Problems	Yes	No	Heart Murmur	Yes	No	Sickle Cell Disease	Yes	No
Bleeding Problems	Yes	No	Heart Defects	Yes	No	Sinus Problems	Yes	No
Blood Disease	Yes	No	Heart Problems	Yes	No	Skin Disease	Yes	No
Blood Transfusions	Yes	No	Hepatitis A B C or D	Yes	No	Stomach Problems	Yes	No
Bruise Easily	Yes	No	Herpes	Yes	No	Stroke	Yes	No
Cancer	Yes	No	High Blood Pressure	Yes	No	Surgeries	Yes	No
Chemotherapy	Yes	No	Insomnia/Frequent Waking	Yes	No	Swollen Ankles	Yes	No
Chest Pain	Yes	No	Jaundice	Yes	No	Thyroid Problems	Yes	No
Clenching of Teeth	Yes	No	Jaw Pain	Yes	No	Tingling in Arms/Fingers	Yes	No
Congested Ears	Yes	No	Jaw Popping	Yes	No	Trigeminal Neuralgia	Yes	No
COPD	Yes	No	Kidney Disease	Yes	No	Tuberculosis	Yes	No
Diabetes	Yes	No	Latex Allergy/Sensitivity	Yes	No	Tumors	Yes	No
Difficulty Chewing	Yes	No	Limited Opening	Yes	No	Ulcers	Yes	No
Difficulty Swallowing	Yes	No	Liver Disease	Yes	No	Weight Loss/Gain	Yes	No
Dizziness	Yes	No	Loose Teeth	Yes	No			

Do you have or have you had any disease, condition or problem not listed? Yes No

If Yes, Please

Explain: _____

Does Food Pack or Catch Between Your Teeth? Yes No

Do Your Gums Bleed? Yes No

Does Your Breath Concern You? Yes No

Dental Insurance Information

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone No. _____

Do you have dual coverage? Yes _____ No _____ If yes:

Insured's Name _____ Insured's Social Security # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____ Phone No. _____