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| **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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  HomeAddress:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Have You Been Admitted to the Hospital or Needed Emergency Care During The Past Two Years? Yes No  If Yes, Please Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Are You Taking Birth Control Pills? Yes No  If Yes, Please Provide Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Are you Pregnant, or Trying to Become Pregnant? Yes No  If Yes, How Many Weeks?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  When is Your Due Date?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Are you Nursing? Yes No  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:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PLEASE LIST ANY MEDICATION YOU MAY BE CURRENTLY TAKING  |  |  |  |  |  | | --- | --- | --- | --- | --- | | MEDICATION | DOSAGE | HOW OFTEN | ROUTE (ORAL/INJECTION) | WHAT IS MEDICATION TAKEN FOR? | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  | |  |  |  |  |  |  MEDICAL HISTORY CONTINUED **HAVE YOU EVER EXPERIENCED OR HAD ANY OF THE FOLLOWING? PLEASE** **MARK YES OR NO TO EACH ITEM.**   |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | | AIDS/HIV | □Yes □No |  | Hepatitis A B C or D | □Yes □No |  |  |  | | Allergies | □Yes □No |  | Herpes | □Yes □No | | Anemia | □Yes □No |  | High Blood Pressure | □Yes □No | | Arthritis/Rheumatism | □Yes □No |  | Hives/Rash | □Yes □No | | Artificial Joints | □Yes □No |  | Insomnia/Frequent Waking | □Yes □No | | Artificial Heart Valve | □Yes □No |  | Jaundice | □Yes □No | | Asthma | □Yes □No |  | Kidney Disease | □Yes □No | | Autism | □Yes □No |  | Liver Disease | □Yes □No | | Back Problems | □Yes □No |  | Mental Illness | □Yes □No | | Bell's Palsy | □Yes □No |  | Multiple Sclerosis | □Yes □No | | Bladder Disease/Problems | □Yes □No |  | Nervous Problems | □Yes □No | | Bleeding Problems | □Yes □No |  | Prosthetic Heart Valve | □Yes □No | | Blood Transfusions | □Yes □No |  | Psychiatric Care | □Yes □No | | Bruise Easily | □Yes □No |  | Radiation Treatment | □Yes □No | | Cancer | □Yes □No |  | Respiratory Problems | □Yes □No | | Circulatory Problems | □Yes □No |  | Rheumatic Fever | □Yes □No | | Chemotherapy | □Yes □No |  | Ringing of Ears | □Yes □No | | Chest Pain | □Yes □No |  | Sexually Transmitted Disease | □Yes □No | | Crohn’s Disease | □Yes □No |  | Shingles | □Yes □No | | Congested Ears | □Yes □No |  | Sickle Cell Disease | □Yes □No | | COPD | □Yes □No |  | Sinus Problems | □Yes □No | | Diabetes | □Yes □No |  | Skin Rash/Disease | □Yes □No | | Dizziness or Fainting | □Yes □No |  | Stomach Problems | □Yes □No | | Down Syndrome | □Yes □No |  | Stroke | □Yes □No | | Epilepsy | □Yes □No |  | Surgeries | □Yes □No | | Fibromyalgia | □Yes □No |  | Swelling of the Limbs | □Yes □No | | Glaucoma | □Yes □No |  | Thyroid Problems | □Yes □No | | Gout | □Yes □No |  | Tingling in Arms/Fingers | □Yes □No | | Headaches | □Yes □No |  | Tuberculosis | □Yes □No | | Heart Attack | □Yes □No |  | Tumor or Growths | □Yes □No | | Heart Murmur | □Yes □No |  | Ulcers | □Yes □No | | Heart Pacemaker | □Yes □No |  | Weight Loss/Gain | □Yes □No |   Do you have or have you had any disease, condition or problem not listed? Yes No  If Yes, Please Explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Do any of the Following Dental Concerns Apply to you?**   |  |  | | --- | --- | | Bad Breath | □Yes □No | | Bleeding Gums | □Yes □No | | Blisters on Lips or Mouth | □Yes □No | | Burning Sensation on Tongue | □Yes □No | | Clicking or Popping Jaw and or swollen/tender | □Yes □No | | Clenching or Grinding of Your Teeth | □Yes □No | | Dry Mouth | □Yes □No | | Food Collecting/Packing Between Teeth | □Yes □No | | Lip or Cheek Biting | □Yes □No | | Loose or Broken Teeth | □Yes □No | | Loose or Broken Fillings/Crowns | □Yes □No | | Missing Teeth | □Yes □No | | Sensitivity to Pressure or Other: (cold, heat, sweets) | □Yes □No | | Stained/Darker Than Normal Teeth | □Yes □No | | Spaces/Gaps Between Teeth | □Yes □No | | Tooth Ache(s) | □Yes □No | | Other Dental Concerns (Please List): | □Yes □No | |  |  | |  |  |   I have answered all the questions to the best of my knowledge. Should further information be needed, I grant permission to ask my respective healthcare providers or agencies, who may release information to you. I will notify the dentist of any changes in my heath or medication.    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Patient, parent, or legal guardian signature Date |  |  |