DENTAL HISTORY

Please check any of the following that apply to you:

- -Sensitivity (hot, cold, sweet) ☐
  Where? UR LR UL LL
- -Headaches, ear aches, neck or jaw joint pain ☐
- -Mouth ulcers or cold sores ☐
- -Teeth or fillings breaking ☐
- -Grinding or clenching teeth ☐
- -Bleeding, swollen or irritated gums ☐
- -Loose, tipped or shifting teeth ☐
- -Bad breath ☐

Do you have or have you had any of the following?

- -Dentures ☐
- -Partial dentures ☐
- -Braces ☐
- -Gum treatments ☐

Please share the following dates:

- -Your last cleaning ____/____
- -Your last oral cancer screening ____/____
- -Your last complete X-Rays ____/____

Name of Previous Dentist

____

City ____________________ **State** __________

Phone Number ______________________________

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

If you could whiten your teeth for a cost anyone could afford, would you do it? ☐

Do you smoke or use chewing tobacco? ☐

How much? For how long?

If I could change my smile, I would: ☐

- -Make my teeth whiter ☐
- -Make my teeth straighter ☐
- -Close spaces ☐
- -Replace metal fillings with tooth colored restorations ☐
- -Repair chipped teeth ☐
- -Replace missing teeth ☐
- -Replace old crowns that don't match ☐
- -Have a smile makeover ☐

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

Why did you leave your previous dentist?

____

____

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

MEDICAL HISTORY

Please check any of the following that apply to you:

☐ Allergies (Seasonal)	☐ Excessive Bleeding	☐ Nervousness/Depression	☐ Ulcers
☐ Anemia	☐ Glaucoma	☐ Pacemaker	☐ Snoring
☐ Artificial Heart Valve	☐ Heart Conditions	☐ Phen Fen (1 month +)	☐ Sleep Apnea
☐ Artificial Joints	☐ Heart Murmur	☐ Radiation (head/neck)	☐ Fatigue
☐ Asthma	☐ Hepatitis A	☐ Respiratory Problems	☐ Migraines
☐ Blood Disease	☐ Hepatitis B	☐ Rheumatic Fever	☐ Chronic Pain
☐ Bruise Easily	☐ Hepatitis C	☐ Rheumatism	☐ OTHER (please list):
☐ Cancer	☐ High Blood Pressure	☐ Scarlet Fever	________________
☐ Chemotherapy	☐ HIV/AIDS	☐ Seizures	**For WOMEN Only**
☐ Diabetes	☐ Jaundice	☐ Stomach Problems	☐ Birth Control Pills
☐ Dizziness/Fainting	☐ Kidney Disease	☐ Stroke	☐ Breast-feeding
☐ Drug Addiction	☐ Liver Disease	☐ Thyroid Disease	☐ Pregnant
☐ Emphysema	☐ Mitral Valve Prolapse	☐ Tuberculosis	1-3 mos,3-6 mos,6-9mos,

Do you have an allergy to any of the following?

☐ Aspirin	☐ Codeine
☐ Erythromycin	☐ Other:
☐ Latex	____________
☐ Local Anesthetic	____________
☐ Nitrous Oxide	____________
☐ Penicillin	____________

What medications are you currently taking?

____

____

____

Are you under a physician's care? For what?

____

Family Physician ________________ **Phone Number** ________________