PATIENT DENTAL HISTORY

PATIENT'S NAME_____DATE OF BIRTH_____

REASON FOR THIS VISIT_____

WHEN WAS YOUR LAST DENTAL VISIT_____WHAT WAS DONE THEN_____

HOW OFTEN DID YOU VISIT THE DENTIST BEFORE THEN_____

PREVIOUS DENTIST (NAME AND LOCATION)_____

HAVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS, WHEN_____

HOW OFTEN DO YOU BRUSH YOUR TEETH_____HOW OFTEN DO YOU FLOSS_____

	YES	NO
DO YOUR GUMS BLEED WHILE BRUSHING.....	☐	☐
ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS.....	☐	☐
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS.....	☐	☐
DO YOU FEEL PAIN TO ANY OF YOUR TEETH	☐	☐
DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH.....	☐	☐
HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES	☐	☐
HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?		
CLICKING.....	☐	☐
PAIN(JOINT, EAR,SIDE OF FACE).....	☐	☐
DIFFICULTY IN OPENING OR CLOSING.....	☐	☐
DIFFICULTY IN CHEWING.....	☐	☐
DO YOU HAVE FREQUENT HEADACHES.....	☐	☐
DO YOU CLENCH AND GRIND YOUR TEETH.....	☐	☐

	YES	NO
DO YOU BITE YOUR LIPS OR CHEEKS.....	☐	☐
HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH.....	☐	☐
DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH.....	☐	☐
HAVE YOU EVER HAD PERIODONTAL TREATMENT	☐	☐
EVER WORN A BITE PLATE OR OTHER APPLIANCE	☐	☐
HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS	☐	☐
HAVE YOU EVER HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS.....	☐	☐
DO YOU WEAR DENTURES OR PARTIALS.....	☐	☐
IF YES, DATE OF PLACEMENT_____		
HAVE YOU EVER RECEIVED ORAL HYGIENE INSTRUCTION REGARDING THE CARE OF YOUR TEETH AND GUMS	☐	☐
DO YOU SUFFER FROM SLEEP APNEA.....	☐	☐

IF YOU COULD CHANGE <u>ANYTHING</u> ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE? _____

_____

_____

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 TRREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CAERE TO THIRD PARTY PAYORS AND.OR HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUPINSURANCE BENEFITS ORTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

_____ _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR DATE

DOCTOR'S COMMENTS_____

_____

SIGNATURE _____DATE_____

PATIENT MEDICAL HISTORY

PATIENT'S NAME_____DATE OF BIRTH_____

ALTHOUGH DENTAL PROFESSIONALS PRIMAILY TREAT THE AREA IN AND AROUND THE MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATION THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

	YES	NO
1. ARE YOU IN GOOD HEALTH?	☐	☐
2. HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR?	☐	☐
3. DATE OF YOUR LAST EXAM?	☐	☐
4. PHYSICIAN'S NAME_____ ADDRESS_____ PHONE NO._____		
5. ARE YOU UNDER THE CARE OF A PHYSCIAN?	☐	☐
6. HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGERY OR SERIOUS ILLNESS?	☐	☐
IF YES PLEASE EXPLAIN._____ _____		
7. ARE YOU TAKING ANY MEDICINE(S)	☐	☐
IF YES PLEASE LIST_____ _____		
8. HAVE YOU HAD ANY ABNORMAL BLEEDING?	☐	☐
9. DO YOU BRUISE EASILY?	☐	☐
10. HAVE YOU BEEN TREATED FOR GLAUCOMA?	☐	☐

ARE YOU ALLERGIC TO OR HAVE YOU HAD REACTIONS TO:	YES	NO
LOCAL ANESTHETICS LIKE NOVICAINE	☐	☐
PENICILLIN	☐	☐
OTHER ANTIBIOTICS	☐	☐
SULFA DRUGS	☐	☐
BARBITURATES OR SEDATIVES	☐	☐
ASPRIN	☐	☐
IODINE	☐	☐
ANY METALS (NICKEL, MERCURY, E.G., ETC)	☐	☐
LATEX/RUBBER	☐	☐

DO YOU HAVE OR HAVE YOU EVER HAD THE FOLLOWING:		
RHEUMATIC HEART DISEASE OR RHEUMATIC FEVER	☐	☐
SCARLET FEVER	☐	☐
HEART DEFECT OR MURMUR	☐	☐
HEART ATTACK OR ANGINA	☐	☐
CHEST PAIN	☐	☐
SHORTNESS OF BREATH	☐	☐
PACEMAKER	☐	☐
HEART SURGERY	☐	☐
HIGH/LOW BLOOD PRESSURE	☐	☐
CONGENITAL HEART PROBLEMS	☐	☐
SWELLING OF FEET, ANKLES, HANDS	☐	☐
HEPATITIS, JAUDICE OR LIVER DISEASE	☐	☐
STROKE	☐	☐
SINUS TROUBLE	☐	☐
BREATHING OR LUNG PROBLEMS	☐	☐
ASTHMA OR HAY FEVER	☐	☐
DO YOU SNORE	☐	☐

	YES	NO
10. HAVE YOU EVER REQUIRED A BLOOD TRANSFUSION?	☐	☐
11. HAVE YOU HAD A RECENT WEIGHT LOSS?	☐	☐
12. HAVE YOU EVER TAKEN FEN-PHEN/REDUX	☐	☐
13. DO YOU USE TOBACCO?	☐	☐
14. DO YOU OR HAVE YOU USED CONTROLLED SUBSTANCES?	☐	☐
15. ARE YOU WEARING CONTACT LENSES?	☐	☐
16. DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS?	☐	☐
17.DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT	☐	☐

	YES	NO
AUTISM	☐	☐
HIVES OR SKIN RASH	☐	☐
FAINTING OR DIZZY SPELLS	☐	☐
DIABETES	☐	☐
AIDS OR HIV INFECTION	☐	☐
THYROID PROBLEM	☐	☐
ALLERGIES	☐	☐
ARTHRITIS OR RHEUMATISM	☐	☐
JOINT REPLACMENT	☐	☐
STOMACH ULCER	☐	☐
KIDNEY TROUBLE	☐	☐
TUBERCULOSIS	☐	☐
PERSISTENT COUGH	☐	☐
COUGH THAT PRODUCES BLOOD	☐	☐
CHEMOTHERAPY	☐	☐
SEXUALLY TRANSMITTED DISEASE	☐	☐
EPILEPSY OR SEIZURE	☐	☐
ANEMIA	☐	☐
NERVOUSNESS	☐	☐
TONSILLITIS	☐	☐
TUMORS	☐	☐
MENTAL HEALTH CARE	☐	☐
BACK PROBLEMS	☐	☐
CHEMICAL DEPENDENCY	☐	☐
MITRAL VALVE PROLAPSE	☐	☐
CORTISONE TREATMENT	☐	☐
COLD SORES/FEVER BLISTERS	☐	☐
HYPOGLYCEMIA	☐	☐
EATING DISORDERS	☐	☐

WOMEN ONLY:

ARE YOU PREGNANT OR THINK YOU MAY BE	☐	☐
ARE YOU NURSING	☐	☐
ARE YOU TAKING BIRTH CONTROL	☐	☐