Patient Name_____Birth Date_____

Dental History

What would you like us to do today? _____Are you in discomfort?_____

Former Dentist _____ Address_____Phone_____

Date of last X-RAYS_____ Date of last dental care _____

Please circle Yes or No if you have any of the following

Y N Bad breath	Y N Sensitivity to hot or cold	Y N Clicking/Popping of the Jaw	Y N Food Collection between teeth
Y N Bleeding Gums	Y N Sensitivity when biting	Y N Headaches or jaw/joint pain	Y N Sores in mouth
Y N Periodontal Treatment	Y N Loose teeth/broken fillings	Y N Grinding the teeth	Y N Dry mouth

Please describe current dental problems_____

How often do you brush?_____Floss?_____Do you smoke? Y N How much per day?_____

How do you feel about the appearance of your teeth?_____Are you interested in whitening?_____

Have you ever had an adverse reaction to any dental procedure or any bad experience?_____

Medical History

Physician's Name_____ Address_____

Phone_____ Email_____ Date of last visit_____

Have you had any serious illness or operations? Y N If yes, describe_____

Are you currently under physicians care? Y N If yes, describe_____

Are you currently taking blood thinners (including Warfarin or Aspirin)? Please List_____

Are you on or have you ever taken medication for Bone Metabolism/Osteoporosis (Including Fosamax, Boniva or Actonel)?

Please list_____

Are you allergic to any of the following?

Penicillin Latex Aspirin Codeine Acrylic Metal Local Anesthetics Other

Please list any other allergies_____

Women: Are you pregnant? Y N Nursing? Y N Taking birth control pills? Y N

Circle if you have had or currently have any of the following:

Y N AIDS or HIV	Y N Hemophilia	Y N Surgical Implants	Y N Heart Problems
Y N Alcohol /Drug Abuse	Y N Excessive Bleeding	Y N Thyroid Disease	Y N Congenital Heart Disorder
Y N Artificial Joints	Y N Heredity Problems	Y N Tuberculosis	Y N Infective Endocarditis
Y N Asthma	Y N Herpes/Cold Sores	Y N Coughing up blood	Y N Prosthetic Cardiac valve
Y N Blood Disease	Y N Hepatitis	Y N Heart Murmur	Y N Stomach/Intestinal Disease
Y N Cancer, Chemo Therapy	Y N Kidney Disease	Y N Ulcerative Colitis	Y N Mitral Valve Prolapse
Y N Radiation Treatment	Y N Liver Disease	Y N Acid Reflux	Y N Pace Maker/ Heart Surgery
Y N Cortisone Treatment	Y N Glaucoma	Y N Venereal Disease	Y N Heart Attack
Y N Diabetes	Y N Psychiatric Care	Y N Sinus Trouble	Y N Angina/Chest Pain
Y N Fainting	Y N Seizures/ Epilepsy	Y N Immunosuppression	Y N Lung/Respiratory Disease
Y N Stroke	Y N Osteoporosis	Y N Sleep Apnea	Y N Other _____

Please list all medications you are currently taking: 1._____ 2._____

3. _____ 4._____ 5._____ 6._____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in my medical status

Signature of Patient, parent, or Guardian_____ Date_____