



Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient name: _____ Date of birth: _____ Sex: _____ Age: _____

Home address: _____ City: _____ State: _____ Zip: _____

Billing address (if different): _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell: _____ E-mail: _____

Employer/Occupation: _____ Business phone: _____

Spouse's name & phone #: _____ Emergency phone # (other than spouse): _____

Primary dental insurance: _____ ID #: _____ Group #: _____

Secondary dental insurance: _____ ID #: _____ Group #: _____

Subscriber's name: _____ Date of birth: _____

Name of your medical doctor: _____ Date of last visit to medical doctor: _____

Name of previous dentist: _____ Date of last visit to dentist: _____

Referred to us by: _____

DENTAL HEALTH HISTORY

	Yes	No		Yes	No
Are you apprehensive about dental treatment? _____	<input type="checkbox"/>	<input type="checkbox"/>	How often do you brush? _____		
Have you had problems with previous dental treatment? _____	<input type="checkbox"/>	<input type="checkbox"/>	How often do you floss? _____		
Do you gag easily? _____	<input type="checkbox"/>	<input type="checkbox"/>	Does your jaw make noise so that it bothers you or others? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear dentures? _____	<input type="checkbox"/>	<input type="checkbox"/>	Do you clench or grind your jaws frequently? _____	<input type="checkbox"/>	<input type="checkbox"/>
Does food catch between your teeth? _____	<input type="checkbox"/>	<input type="checkbox"/>	Do your jaws ever feel tired? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have difficulty in chewing your food? _____	<input type="checkbox"/>	<input type="checkbox"/>	Does your jaw get stuck so that you can't open freely? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you chew on only one side of your mouth? _____	<input type="checkbox"/>	<input type="checkbox"/>	Does it hurt when you chew or open wide to take a bite? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you avoid brushing any part of your mouth because of pain? _____	<input type="checkbox"/>	<input type="checkbox"/>	Do you have earaches or pain in front of the ears? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed easily? _____	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any jaw symptoms or headaches upon awaking in the morning? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed when you floss? _____	<input type="checkbox"/>	<input type="checkbox"/>	Do you find jaw pain or discomfort extremely frustrating or depressing? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums feel swollen or tender? _____	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a temporomandibular (jaw) disorder (TMD)? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever noticed slow-healing sores in or about your mouth? _____	<input type="checkbox"/>	<input type="checkbox"/>	Do you have pain in the face, cheeks, jaws, joints, throat, or temples? _____	<input type="checkbox"/>	<input type="checkbox"/>



DENTAL HEALTH HISTORY continued

	Yes	No		Yes	No
Are your teeth sensitive? _____	<input type="checkbox"/>	<input type="checkbox"/>	Are you unable to open your mouth as far as you want? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel twinges of pain when your teeth come in contact with:			Are you aware of an uncomfortable bite? _____	<input type="checkbox"/>	<input type="checkbox"/>
Hot foods or liquids? _____	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a blow to the jaw (trauma)? _____	<input type="checkbox"/>	<input type="checkbox"/>
Cold foods or liquids? _____	<input type="checkbox"/>	<input type="checkbox"/>	Are you a habitual gum chewer or pipe smoker? _____	<input type="checkbox"/>	<input type="checkbox"/>
Sours? _____	<input type="checkbox"/>	<input type="checkbox"/>	Do you want complete dental care? _____	<input type="checkbox"/>	<input type="checkbox"/>
Sweets? _____	<input type="checkbox"/>	<input type="checkbox"/>	Do you prefer to save your teeth? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you take fluoride supplements? _____	<input type="checkbox"/>	<input type="checkbox"/>			
Are you dissatisfied with the appearance of your teeth? _____	<input type="checkbox"/>	<input type="checkbox"/>			

How do you feel about dental treatment? Relaxed A little uneasy Tense Anxious Very Anxious

If you could change your smile, what would you change?

- Remove unsightly fillings Straighten teeth Change shape of teeth Close gaps between teeth
 Replace missing teeth Whitening Make teeth same color Other _____

MEDICAL HEALTH HISTORY

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

	Yes	No		Yes	No
Heart Problems			Fainting Spells, Seizures, or Epilepsy _____	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain _____	<input type="checkbox"/>	<input type="checkbox"/>	Stroke(s) _____	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath _____	<input type="checkbox"/>	<input type="checkbox"/>	Frequent or severe headaches _____	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure problem _____	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur _____	<input type="checkbox"/>	<input type="checkbox"/>	Persistent cough or swollen glands _____	<input type="checkbox"/>	<input type="checkbox"/>
Heart valve problem _____	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis or other respiratory disease _____	<input type="checkbox"/>	<input type="checkbox"/>
Taking heart medication _____	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, jaundice, or liver trouble _____	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever _____	<input type="checkbox"/>	<input type="checkbox"/>	Herpes or other STD _____	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker _____	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valve _____	<input type="checkbox"/>	<input type="checkbox"/>	HIV-positive/AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
Blood Problems			Do you wear contact lenses? _____	<input type="checkbox"/>	<input type="checkbox"/>
Easy bruising _____	<input type="checkbox"/>	<input type="checkbox"/>	History of head injury? _____	<input type="checkbox"/>	<input type="checkbox"/>
Frequent nosebleeds _____	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes		
Abnormal bleeding _____	<input type="checkbox"/>	<input type="checkbox"/>	Urinate more than 6 times a day _____	<input type="checkbox"/>	<input type="checkbox"/>
Blood disease (anemia) _____	<input type="checkbox"/>	<input type="checkbox"/>	Thirsty or mouth is dry much of the time _____	<input type="checkbox"/>	<input type="checkbox"/>
Ever require a blood transfusion? _____	<input type="checkbox"/>	<input type="checkbox"/>	Family history of diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>
Allergy Problems			Do you drink alcohol? _____	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>	If so, how much? _____		
Sinus problems _____	<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke? _____	<input type="checkbox"/>	<input type="checkbox"/>
Skin rashes _____	<input type="checkbox"/>	<input type="checkbox"/>	If so, how much? _____		
Taking allergy medication _____	<input type="checkbox"/>	<input type="checkbox"/>			
Asthma _____	<input type="checkbox"/>	<input type="checkbox"/>			
Intestinal Problems					
Ulcers _____	<input type="checkbox"/>	<input type="checkbox"/>			
Weight gain or loss _____	<input type="checkbox"/>	<input type="checkbox"/>			
Special diet _____	<input type="checkbox"/>	<input type="checkbox"/>			
Constipation/Diarrhea _____	<input type="checkbox"/>	<input type="checkbox"/>			
Kidney or bladder problems _____	<input type="checkbox"/>	<input type="checkbox"/>			



MEDICAL HEALTH HISTORY continued

	Yes	No
Bone or Joint Problems		
Arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>
Back or neck pain _____	<input type="checkbox"/>	<input type="checkbox"/>
Joint replacement _____	<input type="checkbox"/>	<input type="checkbox"/>
(e.g., total hip, pins, or implants) _____	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
Epilepsy or other neurological disease? _____	<input type="checkbox"/>	<input type="checkbox"/>
History of alcohol or drug abuse? _____	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any disease, condition, or problem not listed previously that you feel we should know about?

If so, please describe: _____

Are you allergic, or have you reacted adversely, to any of the following?

	Yes	No
Local anesthetics ("Novocaine") _____	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics _____	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs _____	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives, or sleeping pills _____	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin, Acetaminophen, or Ibuprofen _____	<input type="checkbox"/>	<input type="checkbox"/>
Codeine, Demerol, or other narcotics _____	<input type="checkbox"/>	<input type="checkbox"/>
Reaction to metals _____	<input type="checkbox"/>	<input type="checkbox"/>
Latex or rubber dam _____	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

During the past 12 months, have you taken any of the following?

	Yes	No
Antibiotics or sulfa drugs _____	<input type="checkbox"/>	<input type="checkbox"/>
Anticoagulants (e.g., Coumadin) _____	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure medicine _____	<input type="checkbox"/>	<input type="checkbox"/>
Tranquilizers _____	<input type="checkbox"/>	<input type="checkbox"/>
Insulin, Orinase, or similar drug _____	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin _____	<input type="checkbox"/>	<input type="checkbox"/>
Digitalis or drugs for heart trouble _____	<input type="checkbox"/>	<input type="checkbox"/>
Nitroglycerin _____	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone (steroids) _____	<input type="checkbox"/>	<input type="checkbox"/>
Natural remedies _____	<input type="checkbox"/>	<input type="checkbox"/>
Nonprescription drug/supplements _____	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

Women

Are you taking contraceptives or other hormones? _	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant? _____	<input type="checkbox"/>	<input type="checkbox"/>
If so, expected delivery date: _____		
Are you nursing? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you reached menopause? _____	<input type="checkbox"/>	<input type="checkbox"/>
If so, do you have any symptoms? _____	<input type="checkbox"/>	<input type="checkbox"/>

Please List Medications

Notes:

Patient/Parent Signature: _____

Date: _____

Dentist Initial: