PATIENT NAME DATE

|  |  |
| --- | --- |
| What may we do for you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
|  | Please Circle |
| Dental History |  |
| Do you have a dental examination on a routine basis? Last visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Yes No |
| Do your gums ever bleed? Discuss \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Yes No |
| If you could change anything about your teeth or smile, what would you change? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| What would you like your teeth to be like in 20 years? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? \_\_\_\_\_\_\_\_\_\_\_\_ | Yes No |
| Have your past experiences in a dental office always been positive? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Yes No |
| Do you smoke or chew, or have any sores or growths in your mouth? Discuss\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Yes No |
| Name of previous dentist (optional): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Date of last full mouth x-rays (16 small films or panoramic): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |

Medical History

|  |  |
| --- | --- |
| Do you presently have any conditions our staff should be aware of? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Yes No |
| Are you under a physician’s care now? Why? Who? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_ | Yes No |
| Have you ever been hospitalized or had a major operation? Discuss \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Yes No |
| Have you ever had a serious injury to you head or neck? Discuss \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Yes No |
| Are you taking any medication, pills or drugs? What? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Yes No |
| Are you on a special diet? Discuss \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Yes No |
| Are you allergic to any medications or substances? Please check box below | Yes No |
|  Aspirin Penicillin Codeine Acrylic Metal Latex Rubber Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Have you received any medications in the last month? | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| \*If yes to any of the starred conditions listed below, please call prior to your appointment…Premedication may be required | | | | | | | | | | | | | | |
|  | Y | N |  | Y | N |  | Y | N |  | Y | N |  | Y | N |
| Heart Trouble/  Disease |  |  | Low Blood Pressure |  |  | Emphysema |  |  | Hepatitis B or C |  |  | Cold Sores |  |  |
| Heart Murmur\* |  |  | Blood Disease |  |  | Tuberculosis |  |  | Kidney Problems |  |  | Fever Blisters |  |  |
| Irregular Heart Beat |  |  | Bruise Easily |  |  | Cancer |  |  | Renal Dialysis |  |  | Herpes |  |  |
| Angina/  Chest Pain |  |  | Anemia |  |  | X-Ray Treatments (Radiation) |  |  | Thyroid Disease |  |  | Stroke |  |  |
| Heart Attack or Failure |  |  | Excessive Bleeding |  |  | Chemotherapy |  |  | Parathyroid Disease |  |  | Convulsions |  |  |
| Congenital Heart Disorder |  |  | Sickle Cell Disease |  |  | Ulcers |  |  | Arthritis/Gout |  |  | Epilepsy or Seizures |  |  |
| Mitral Valve Prolapse\* |  |  | Hemophilia (Bleeding Problem) |  |  | Recent Weight Loss |  |  | Pain in Jaw Joints |  |  | Fainting or Dizziness |  |  |
| Scarlet Fever |  |  | Leukemia |  |  | Frequent Diarrhea |  |  | Artificial Joint\* |  |  | Glaucoma |  |  |
| Rheumatic Fever\* |  |  | Recent Blood Transfusion |  |  | Diabetes |  |  | Cortisone Medicine |  |  | Nervousness |  |  |
| Artificial Heart Valve |  |  | Lung Disease |  |  | Excessive Thirst |  |  | Venereal Disease |  |  | Numbness/Tingling |  |  |
| Heart Pace Maker |  |  | Breathing Problem |  |  | Hypoglycemia |  |  | AIDS |  |  | Psychiatric Care |  |  |
| Heart Surgery\* |  |  | Sinus Trouble |  |  | Liver Disease |  |  | HIV Positive |  |  | Allergies (Medicines) |  |  |
| High Blood Pressure |  |  | Asthma |  |  | Hepatitis A (Infectious) |  |  | Drug Addiction |  |  | Allergies (Pollen/Dust) |  |  |

Have you ever had any other serious illness not checked above? Discuss \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Yes No

*To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.*

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

History Review and Significant Findings:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Date | Exceptions |  | Initials | Date | Exceptions |  | Initials |
|  |  | None  |  |  |  | None  |  |
|  |  | None  |  |  |  | None  |  |
|  |  | None  |  |  |  | None  |  |