Dental Information

Reason for today's visit: ☐ Exam ☐ Emergency ☐ Consultation Are you in pain? ☐ No ☐ Yes How long? _____

Please indicate any of the following problems:

☐ Discomfort, clicking or popping jaw ☐ Lost/Broken filling(s) ☐ Stained teeth ☐ Locking jaw

☐ Sensitive tooth, teeth or gums ☐ Teeth grinding ☐ Bad breath ☐ Ringing in ears

☐ Blisters/Sores in or around mouth ☐ Broken/Chipped tooth ☐ Red, swollen or bleeding gums

☐ Other _____

Do you require pre-medication? ☐ Yes ☐ No ☐ Don't Know

Previous Dentist? _____ Previous Dentist Ph: _____

Last Dental Exam: _____ Last Dental X-rays _____ Times a day you brush? _____ Times a week you floss? _____

What type of toothbrush bristles do you use? ☐ Soft ☐ Medium ☐ Hard

How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

Medical History

Date of Last Physician's Exam: _____ Reason for Visit: _____

Have you or are you taking any of the following medications? ☐ Zometa ☐ Aredia ☐ Fosamax ☐ Boniva ☐ Actonel

☐ Insulin ☐ Muscle relaxers ☐ Stimulants ☐ Tranquilizers ☐ Pain Killers (including asprin)

☐ Blood Thinners ☐ Anti-Depressants ☐ Other(s), please list: _____

Do you have or have had any of the following diseases, medical conditions or procedures?

	Yes	No		Yes	No		Yes	No
Heart Attack/Stroke	☐	☐	Stomach Problems / Ulcers	☐	☐	Frequent Neck Pain	☐	☐
Heart Surgery / Pacemaker	☐	☐	Psychiatric Problems	☐	☐	Back Problems	☐	☐
Heart Murmur	☐	☐	Venereal Disease	☐	☐	Cosmetic Procedures	☐	☐
Rheumatic Fever	☐	☐	Alcohol/Drug Abuse	☐	☐	X-Ray or Cobalt Treatment	☐	☐
Mitral Valve Prolapse	☐	☐	Tuberculosis (TB)	☐	☐	Chemotherapy	☐	☐
Artificial Valves	☐	☐	Jaw Problems TMJ/TMD	☐	☐	Asthma	☐	☐
Heart Disease	☐	☐	Cancer/Tumors	☐	☐	Difficulty Breathing	☐	☐
Congenital Heart Defect	☐	☐	Shingles	☐	☐	Diabetes / Hypoglycemia	☐	☐
Chest Pains	☐	☐	Hepatitis	☐	☐	Leukemia	☐	☐
Scarlet Fever	☐	☐	HIV+/AIDS/ARC	☐	☐	Anemia	☐	☐
Thyroid Problems	☐	☐	Arthritis Bones/Joints	☐	☐	High / Low Blood Pressure	☐	☐
Kidney Problems	☐	☐	Artificial Bones/Joints	☐	☐	Bleeding Problems	☐	☐
Liver Problems	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Respiratory Problems	☐	☐	Fainting/Seizures/Epilepsy	☐	☐			
Sinus Problems	☐	☐	Severe/Frequent Headaches	☐	☐			

Please list any other surgeries or medical conditions you have had: _____

_____

Are you allergic to any of the following: ☐ Latex ☐ Penicillin/Amoxicillin ☐ Tetracycline ☐ Aspirin ☐ Dental Anesthetics?

Other(s), please list: _____

Do you use tobacco? ☐ No ☐ Yes / How Used? _____ How much? _____ How long? _____

For Women: Are you taking Birth Control pills? ☐ Yes ☐ No How many children have you had? _____

Are you pregnant? ☐ No ☐ Yes/How long? _____ Are you nursing? ☐ Yes ☐ No

- We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____ Date: _____ Reviewed By: _____

☐ Adult Patient ☐ Parent or Guardian ☐ Spouse Date: _____