DENTAL HISTORY

Please check any of the following that apply to you:

- Sensitivity (hot, cold, sweet) ☐
  Where? UR LR UL LL
- Headaches, ear aches, neck or jaw joint pain ☐
- Mouth ulcers or cold sores ☐
- Teeth or fillings breaking ☐
- Grinding or clenching teeth ☐
- Bleeding, swollen or irritated gums ☐
- Loose, tipped or shifting teeth ☐
- Bad breath ☐

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

- Dentures ☐
- Partial dentures ☐
- Braces ☐
- Gum treatments ☐

Please share the following dates:

- Your last cleaning ___/___
- Your last oral cancer screening ___/___
- Your last complete X-Rays ___/___

Name of Previous Dentist ____________________

City ____________________ **State** ________

Phone Number ____________________

What is the most important thing to you about your future smile and dental health? ____________________

If you could whiten your teeth for a cost anyone could afford, would you do it? ☐

Do you smoke or use chewing tobacco? ☐

How much? For how long?

If I could change my smile, I would: ☐

- Make my teeth whiter ☐
- Make my teeth straighter ☐
- Close spaces ☐
- Replace metal fillings with tooth colored restorations ☐
- Repair chipped teeth ☐
- Replace missing teeth ☐
- Replace old crowns that don't match ☐
- Have a smile makeover ☐

On a scale of 1 – 10, with 10 being the highest rating:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?

____

____

What is the most important thing to you about your dental visit today? ____________________

MEDICAL HISTORY

Please check any of the following that apply to you:

- ☐ Allergies (Seasonal)
- ☐ Anemia
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Dizziness/Fainting
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Excessive Bleeding
- ☐ Glaucoma
- ☐ Heart Conditions
- ☐ Heart Murmur
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervousness/Depression
- ☐ Pacemaker
- ☐ Phen Fen (1 month +)
- ☐ Radiation (head/neck)
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ OTHER (please list):

____

____

____

____

____

____

For WOMEN Only

- ☐ Birth Control Pills
- ☐ Breast-feeding
- ☐ Pregnant

1-3 mos,3-6 mos,6-9mos,

Do you have an allergy to any of the following?

- ☐ Aspirin
- ☐ Erythromycin
- ☐ Latex
- ☐ Local Anesthetic
- ☐ Nitrous Oxide
- ☐ Penicillin
- ☐ Codeine
- ☐ Other:

____

____

____

____

What medications are you currently taking?

____

____

____

Are you under a physician's care? For what?

____

____

Family Physician ____________________

Phone Number ____________________