PATIENT NAME_____ BIRTHDATE_____

Address Phone

DENTAL HISTORY

Please circle

Do you have a specific dental problem? Describe	Yes	No
Do you have dental examinations on a regular basis? Last visit	Yes	No
Do you brush and floss on a routine basis? Discuss	Yes	No
Do you want to keep your remaining teeth?	Yes	No
Do you like your smile & why?	Yes	No
Do you think you have active decay or gum disease?	Yes	No
Do your gums ever bleed? Discuss.	Yes	No
Do you feel nervous about having dental treatment?	Yes	No
Have you ever had a bad experience in a dental office? Describe	Yes	No

Name of previous dentist (optional)_____ Who referred you to our office_____

Do you ever brux or grind your teeth?	Yes	No
Have you ever had orthodontic treatment (tooth straightening)?	Yes	No
Do you ever have clicking, popping or discomfort in the jaw joints (TMJ) discuss	Yes	No

MEDICAL HISTORY

Medical doctor's name_____ Phone_____

Are you under a doctor's care now? Why?_____

Have you been hospitalized or received a blood transfusion?_____ When_____

Are you currently taking any medications, pills or drugs, including over the counter medications?

What? _____

Women; Are you pregnant?	Yes	No
Are you allergic to any medications or substance?	Yes	No

_____ (penicillin, codeine, metal, latex, rubber, ect)

Please CIRCLE if you have had any of the following:

Heart disease	Chest Pain	Hay fever	Parathyroid Disease	Drug/Alcohol Abuse
Emphysema	Hemophilia	Sinus trouble	Radiation TX	Psychiatric care
Asthma	Thyroid Disease	Scarlet fever	Hypoglycemia	Artificial joints/hips
Stroke	Diabetes	Glaucoma	Sickle cell anemia	Alzheimer's disease
Ulcers	Anemia	Cold sores	Tobacco user	Fainting/dizziness
Kidney trouble	Aids	Yellow Jaundice	Frequent cough	Epilepsy/Seizures
Blood disease	Herpes	Heart surgery	Osteoporosis	
Excessive thirst	Cancer	Pacemaker	Artificial heart valve	Arthritis/Gout
Rheumatism	Merca	Tuberculosis	Low Blood Pressure	High Blood Pressure
Heart murmur	Weight loss	Rheumatic fever	Lung disease	Shortness of breath
Nervousness	Bruise Easily	Chemotherapy	Liver disease	Swelling (feet & ankles)
Hepatitis A	Hepatitis B			

Have you ever had any other serious illness not circled above? Yes No

What? _____

Do you wish to talk to the doctor privately about any problem? Yes No

Patient Signature_____ Date_____

MEDICAL UPDATES

I have read my MEDICAL HISTORY dated _____ and confirm that it adequately states past & present conditions.

Date_____ Exceptions_____ None ___patient signature

X_____

X_____