Patient Medical History

Who is your medical doctor? _____ Phone _____ Last Exam _____

Are you allergic to or made sick by any of the following:

___ Penicillin ___ Codeine ___ Latex ___ Sulfa ___ Aspirin ___ Novocaine ___ Tetracyclene

___ Other drug or material _____

List all medications you are currently taking (include birth control)

_____

Are you currently pregnant? Yes or No

Have you been affected by any of the following:

___ High Blood Pressure
___ Heart Murmur
___ Heart Disease or Attack
___ Artificial Heart Valve
___ Heart Pacemaker
___ Heart Surgery
___ Blood Transfusion
___ Angina Pectoris
___ Rheumatic Fever
___ Mitral Valve Prolapse
___ Anemia
___ Stroke
___ Kidney Problems
___ Other _____

___ Depression
___ Psychiatric Care
___ Emphysema
___ Asthma
___ Tuberculosis (TB)
___ Sinus Trouble
___ High Cholesterol
___ Diabetes
___ Cobalt Treatments
___ Chemotherapy
___ Leukemia
___ Arthritis
___ Ulcers

___ Artificial Joint
___ Hepatitis, which form _____
___ Thyroid Disease
___ Cancer/Tumors
___ Excessive Bleeding
___ Epilepsy or Seizures
___ Allergies/Hives
___ Drug Addiction/Alcoholism
___ Hemophilia
___ Venerial Disease
___ AIDS/HIV
___ Cortisone Medication
___ Eating Disorder

Patient Dental History

Please check any of the following that apply to you.

- Sensitivity (hot, cold, sweet) . . . . . ☐
  Where? UR LR UL LL
- Headaches, earaches, neck pain . . . . . ☐
- Jaw joint pain . . . . . ☐
- 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 them whiter . . . . . ☐
- Make them straighter . . . . . ☐
- Close spaces . . . . . ☐
- Replace black 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 wyould 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? _____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf. I further agree that if I fail to promptly pay such amounts when due, I will be responsible for all resulting costs, expenses and legal fees.

_____ _____

Signature of Patient Date