Patient Name: _____ Birth Date: _____
Last First Middle Initial

Parent/Guardian(s): _____

DENTAL HISTORY

Reason for Today's Visit: _____

Dental concerns we should be aware of: _____

Check (✔) if you have problems with any of the following:

- ❑ Bad breath
- ❑ Bleeding gums
- ❑ Clicking of popping jaw
- ❑ Food collection between teeth
- ❑ Grinding Teeth
- ❑ Loose teeth or broken fillings
- ❑ Peridontal treatment (gums)
- ❑ Sensitivity to cold
- ❑ Sensitivity to Hot
- ❑ Sensitivity to sweets
- ❑ Sensitivity when biting
- ❑ Sores or growths in mouth

Check (✔) if you have problems with any of the following:

- ❑ Whiter Teeth
- ❑ Change shape/appearance
- ❑ Regular care program
- ❑ Replace missing teeth
- ❑ Braces (orthodontics)
- ❑ Other

MEDICAL HISTORY (confidential)

Physicians Name: _____ Phone (____) _____

Women: Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking Birth Control pills? ❑ Yes ❑ No

Have you had any serious illness or operations? _____ If yes, give approximate dates: _____

Check (✔) if you have problems with any of the following:

- ❑ AIDS
- ❑ Anemia
- ❑ Arthritis, Rheumatism
- ❑ Artificial Heart Valves
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Back Problems
- ❑ Blood Disease
- ❑ Cancer
- ❑ Chemical Dependency
- ❑ Chemotherapy
- ❑ Circulatory Problems
- ❑ Cortisone Treatments
- ❑ Cough, Persistent
- ❑ Cough Up Blood
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Fainting
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart Murmur
- ❑ Heart Problems
  Describe _____
- ❑ Hemophilia
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ HIV Positive
- ❑ Jaw Pain
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Mitral Valve Prolapse
- ❑ Nervous Problems
- ❑ Pacemaker
- ❑ Psychiatric Care
- ❑ Radiation Treatment
- ❑ Respiratory Disease
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Shortness of Breath
- ❑ Skin Rash
- ❑ Stroke
- ❑ Swelling of Feet and Ankles
- ❑ Thyroid Problems
- ❑ Tobacco Habit
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Venereal Disease

List medications you are currently taking:

_____

_____

Pharmacy Name _____

Phone: _____

ALLERGIES

- ❑ Aspirin
- ❑ Penicillin
- ❑ Barbituarates (sleeping pills)
- ❑ Sulfa
- ❑ Codeine
- ❑ Erythromycin
- ❑ Local Anesthetic
- ❑ Other _____

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. **I understand the importance of notifying the doctor of any changes upon each visit.**

Date: _____ Signature: _____

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date: _____ Signature: _____

Date	Doctor's Signature	Date	Doctor's Signature	Date	Doctor's Signature
Date	Doctor's Signature	Date	Doctor's Signature	Date	Doctor's Signature
Date	Doctor's Signature	Date	Doctor's Signature	Date	Doctor's Signature