

DENTAL HISTORY

Please check any of the following that apply to you.

- Currently experiencing dental pain/discomfort
- Sensitivity to cold, heat or sweets
If yes, where? UR LR UL LL
- Headaches, earaches, neck pain
- Jaw joint pain
- Teeth or filling breaking
- Grinding or clenching of 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
- Periodontal (gum) treatments

Please share the following dates:

Your last dental cleaning _____/_____/_____
 Your last oral cancer screening _____/_____/_____
 Your last complete X-rays _____/_____/_____

Name of Previous Dentist: _____
 Why did you leave? _____
 What did you like most about your last dentist? _____

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

Do you smoke or use chewing tobacco? Y N
 How much? _____ 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 old crowns that don't match
- Have a smile makeover

On a scale from 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

Where do you want your dental health to be?

1 2 3 4 5 6 7 8 9 10

What is your most important question or concern about your dental visit today? _____

MEDICAL HISTORY

Please check any of the following that apply to you.

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Psychiatric Problems |
| <input type="checkbox"/> Alcohol Abuse | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Angina Pectoris | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Herpes | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Facial Surgery | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Jaw Joint Pain | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pace Maker | |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Pregnant (Currently) | |

Do you have any of the following drug allergies?

- | | |
|---|---------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Erythromycin |
| <input type="checkbox"/> Nitrous Oxide | <input type="checkbox"/> Valium |
| <input type="checkbox"/> Percodan | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Local Anesthetic | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Latex |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Other: _____ |

Are you in currently under the care of a physician? If yes, explain.

Physician's Name: _____

Phone: _____

Please list any medications you are currently taking: _____

Treatment Authorization Form

I hereby authorize and give consent to perform dental services agreed upon between doctor and patient and/or parent or guardian, after thorough explanation and to be necessary and advisable, including any diagnostic aids deemed appropriate by the doctor and the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my dental health and medical condition. Payment for all services rendered are my responsibility.

Signature (Patient, Parent or Responsible Party): _____ Relationship to Patient: _____ Date: _____