DENTAL HISTORY

Date: Birthdate:

Name:

Address:

Postal Code: Daytime Phone #(s):

Email address:

Emergency contact:

Who can we thank for referring you to our office?

Primary Insurance Coverage		
Policy Holder:	Date of Birth:	
Insurance Company: Employer	Policy #:	ID/Cert#:

Secondary Insurance Coverage	Circle one: Spouse Mother Father	
Policy Holder:	Date of Birth:	
Insurance Company: Employer:	Policy #:	ID/Cert#:

MEDICAL HISTORY

Are you currently being treated for any medical condition? YES NO
If yes, please explain:

Are you taking any prescription or non-prescription medications? YES NO
If yes, please list:

Do you have any allergies to any medications such as antibiotics - Penicillin, Sulfa drugs? YES NO

Have you ever been advised against taking any specific type of medication? YES NO

Do you smoke or have you ever smoked? YES NO
If yes, how long and how many cigarettes/day?

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

Heart disease or attack	YES	NO	Epilepsy/seizure(s)	YES	NO
Stroke	YES	NO	Cancer	YES	NO
High blood pressure	YES	NO	Radiation treatment	YES	NO
Heart valve replacement	YES	NO	Chemotherapy	YES	NO
Congenital heart disease	YES	NO	HIV/AIDS	YES	NO
Bleeding disorder	YES	NO	Osteoporosis	YES	NO
Hepatitis	YES	NO	Thyroid disease	YES	NO
Diabetes	YES	NO	Tuberculosis	YES	NO
Joint replacement If yes, when?	YES	NO	Lung disease	YES	NO
			Asthma	YES	NO
Serious operation Please explain:	YES	NO	Serious illness Please explain:	YES	NO

Is there a dental problem you would like treated immediately? YES NO
Please explain:

DENTAL HISTORY

Have you been seeing a dentist regularly?	YES	NO
Date of last dental exam, x-rays & dental cleaning:		
Have you been advised to take antibiotics before a dental appointment?	YES	NO
Have you had orthodontic treatment?	YES	NO
Have you had periodontal treatment?	YES	NO
Have you had any injury or surgery to your jaw or face?	YES	NO
Are you aware of clenching or grinding your teeth while awake or asleep?	YES	NO
Do you wear a night guard or any other appliance?	YES	NO
Do you have pain in your jaw joints or around ears or side of your face?	YES	NO
Do you get recurring sores on your lips, tongue or inside of your mouth?	YES	NO
Do your gums bleed when you brush or floss?	YES	NO
Do you have pain or swelling in your gums?	YES	NO
Have you noticed any loose or shifting teeth?	YES	NO
Is there an area where food catches between your teeth?	YES	NO
Are any of your teeth sensitive to hot or cold or sweets or pressure?	YES	NO
How often do you brush your teeth?		
What type of toothbrush do you use?		
How often do you floss your teeth?		
List any other aids that you use to clean your teeth		
Is there anything about the appearance of your teeth that you would like to change? Please explain:	YES	NO
Have you ever had an upsetting experience in a dental office or any complications with dental treatments? Please explain:	YES	NO

Patient Statement/Consent and Approval:

I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical-dental history.

I authorize the dentist to perform diagnostic procedures and treatment necessary for proper dental care. I also understand that consultation with my medical doctor may be required, and I consent to my physician being contacted if necessary. I understand that my responsibility for payment for all dental services provided for myself or my dependants is mine, and I will assume responsibility for fees associated with these services.

_____ Date:_____

Signature of Patient/Parent/Guardian Print Name of Guardian: _____