



Patient Name _____

DENTAL HISTORY

Patient Account No. _____

Medical Alert _____

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.

What is the reason for your visit today? _____

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____
 What was done at your last dental visit? _____

Previous Dentist's Name _____
 Address _____ State _____ Zip _____
 Telephone _____

How often do you have dental examinations? _____
 How often do you brush your teeth? _____ How often do you floss? _____
 What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes No
 If yes, please describe: _____

Are any of your teeth sensitive to:
 Hot or cold? Yes No
 Sweets? Yes No
 Biting or Chewing? Yes No
 Have you noticed any mouth odors or bad tastes? Yes No
 Do you frequently get cold sores, blisters or
 any other oral lesions? Yes No
Do your gums bleed or hurt? Yes No
 Have your parents experienced gum disease
 or tooth loss? Yes No
 Have you noticed any loose teeth or change
 in your bite? Yes No
 Does food tend to become caught in between
 your teeth? Yes No
 If yes, where? _____

Do you:
 Clench or grind your teeth while awake or asleep? Yes No
 Bite your lips or cheeks regularly? Yes No
 Hold foreign objects with your teeth?
 (pencils, pipe, pins, nails, fingernails) Yes No
 Mouth breath while awake or asleep? Yes No
 Have tired jaws, especially in the morning? Yes No
 Smoke/chew tobacco? Yes No

Have you ever had:
 Orthodontic treatment? Yes No
 Oral surgery? Yes No
 Periodontal treatment? Yes No
 Your teeth ground or the bite adjusted? Yes No
 A bite plate or mouth guard? Yes No
 A serious injury to the mouth or head? Yes No
 If so, please describe, including cause _____

Have you experienced:
 Clicking or popping of the jaw? Yes No
 Pain? (joint, ear, side of face) Yes No
 Difficulty in opening or closing the mouth? Yes No
 Difficulty in chewing on either side of the mouth? Yes No
 Headaches, neckaches or shoulder aches? Yes No
 Sore muscles (neck, shoulders)? Yes No

Are you satisfied with your teeth's appearance? Yes No
 Would you like to keep all of your teeth all of your life? Yes No

Do you feel nervous about having dental treatment? Yes No
 If so, what is your biggest concern?

Have you ever had an upsetting dental experience? Yes No
 If yes, please describe _____

Is there anything else about having dental treatment that you would like us to know? Yes No
 If yes, please describe _____

(Please complete other side)





Patient Name _____

MEDICAL HISTORY

Patient Account No. _____

Medical Alert _____

1. Have you been under the care of a medical doctor during the past two years? Yes No
 If yes, for what? _____
 Physician's Name _____ Phone _____
 Address _____ City _____ State _____ Zip _____
2. Have you taken any medication or drugs during the past two years? Yes No
3. Are you taking any medication, drugs or pills now? Yes No
 If yes, please list name and dosage _____
4. Are you aware of having an allergic (or adverse reaction) to any medication or substance? Yes No
 If yes, please list: _____
5. Have you been a patient in the hospital during the past five years? Yes No
6. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack) Yes	No	Ulcers Yes	No	Hepatitis A (infectious) B (serum) Yes	No
Chest Pain Yes	No	Diabetes Yes	No	Venereal Disease Yes	No
Congenital Heart Disease Yes	No	Thyroid Problems Yes	No	A.I.D.S. Yes	No
Heart Murmur Yes	No	Glaucoma Yes	No	H.I.V. Positive Yes	No
High Blood Pressure Yes	No	Contact lenses Yes	No	Cold Sores/Fever Blisters Yes	No
Mitral Valve Prolapse Yes	No	Emphysema Yes	No	Blood Transfusion Yes	No
Artificial Heart Valve Yes	No	Chronic Cough Yes	No	Hemophilia Yes	No
Heart Pacemaker Yes	No	Tuberculosis Yes	No	Sickle Cell Disease Yes	No
Rheumatic Fever Yes	No	Asthma Yes	No	Bruise Easily Yes	No
Arthritis/Rheumatism Yes	No	Hay Fever Yes	No	Liver Disease Yes	No
Cortisone Medicine Yes	No	Latex Sensitivity Yes	No	Yellow Jaundice Yes	No
Swollen Ankles Yes	No	Allergies or Hives Yes	No	Neurological Disorders Yes	No
Stroke Yes	No	Sinus Trouble Yes	No	Epilepsy or Seizures Yes	No
Diet (Special/ Restricted) Yes	No	Radiation Therapy Yes	No	Fainting or Dizzy Spells Yes	No
Artificial Joints (hip, knee, etc.) Yes	No	Chemotherapy Yes	No	Nervous/Anxious Yes	No
Kidney Trouble Yes	No	Tumors Yes	No	Psychiatric/Psychological Care Yes	No
7. Do you use more than two pillows to sleep? Yes No
8. Have you lost or gained more than 10 pounds in the past year? Yes No
9. Do you have or have you had any disease, condition, or problem not listed? Yes No
 If yes, please list: _____
10. Women. Are you: **Pregnant?** Yes, ___ Months No **Nursing?** Yes No **Taking birth control pills?** Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient /Guardian Signature _____

Date _____

History Review

Doctor Signature _____

Date _____

