Patient's Name _____

DENTAL HISTORY

Please check any of the following problems that apply to you:	YES	NO
- Sensitivity (hot, cold, sweet, pressure)	☐	☐
Where? UR LR UL LL		
- Headaches, earaches, neck pain	☐	☐
- Jaw joint pain	☐	☐
- Teeth or fillings breaking	☐	☐
- Grinding or clinching 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	☐	☐

	YES	NO
If you could whiten our 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 it whiter	☐	☐
- Make it 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	☐	☐

Please share the following dates:
- Your last cleaning _____ / _____
- Your last oral cancer screening _____ / _____
- Your last complete X-Rays _____ / _____

Name of your previous dentist _____
City _____ State _____
Phone Number _____

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

Why did you leave your previous dentist? _____
_____

What is the most important thing to you about your future smile and dental health? _____
What is the most important thing to you about your dental visit today? _____

MEDICAL HISTORY

Please check any of the following problems/conditions that apply to you:

	YES	NO		YES	NO		YES	NO		YES	NO
AIDS	☐	☐	Dizziness	☐	☐	HIV Positive	☐	☐	Scarlet Fever	☐	☐
Allergies (Seasonal)	☐	☐	Drug Addiction	☐	☐	HPV (Human Papilloma Virus)	☐	☐	Seizures	☐	☐
Anemia	☐	☐	Emphysema	☐	☐	Jaundice	☐	☐	Sinus Problems	☐	☐
Angina	☐	☐	Epilepsy	☐	☐	Jaw Joint Pain	☐	☐	Sleep Apnea	☐	☐
Arthritis	☐	☐	Excessive Bleeding	☐	☐	Kidney Disease	☐	☐	Stomach Problems	☐	☐
Artificial Heart Valve	☐	☐	Fainting	☐	☐	Liver Disease	☐	☐	Stroke	☐	☐
Artificial Joints	☐	☐	Glaucoma	☐	☐	Low Blood Pressure	☐	☐	Thyroid Disease	☐	☐
Asthma	☐	☐	Heart Conditions	☐	☐	Mitral Valve Prolapse	☐	☐	Tuberculosis	☐	☐
Blood Disease	☐	☐	Heart Lesions (Congenital)	☐	☐	Nervousness/Depression	☐	☐	Ulcers	☐	☐
Bruise Easily	☐	☐	Heart Murmur	☐	☐	Pacemaker	☐	☐	Venereal Diseases	☐	☐
Cancer	☐	☐	Heart Surgery	☐	☐	Pregnant Currently	☐	☐	Other _____		
Cervical Cancer	☐	☐	Hepatitis A	☐	☐	Radiation (head/neck)	☐	☐	_____		
Chemotherapy	☐	☐	Hepatitis B	☐	☐	Respiratory Problems	☐	☐	_____		
Cortisone Medication	☐	☐	Hepatitis C	☐	☐	Rheumatic Fever	☐	☐	_____		
Diabetes	☐	☐	High Blood Pressure	☐	☐	Rheumatism	☐	☐	_____		

Are you allergic or have you reacted adversely to any of the following medications?

	YES	NO		YES	NO		YES	NO	
Aspirin	☐	☐	Latex	☐	☐	Erythromycin	☐	☐	Other _____
Darvon	☐	☐	Local Anesthetic	☐	☐	Valium	☐	☐	_____
Nitrous Oxide	☐	☐	Tetracycline	☐	☐	Penicillin	☐	☐	_____
Percodan	☐	☐	Coedine	☐	☐	Sulfa	☐	☐	_____

Have you ever taken any of the following medications?

	YES	NO		YES	NO
Actonel	☐	☐	Zometa	☐	☐
Aredia	☐	☐	Boniva	☐	☐
Fosamax	☐	☐	Herbal Supplements	☐	☐
Reclast	☐	☐			

Are you under a physician's care? What for?
_____

What medications are your currently taking?
_____

Family Physician _____ Phone Number _____

Consent:

The undersigned herby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.

Patient Signature (Parent/Guardian if minor) _____ Date _____ Dentist Signature _____