PATIENT NAME: _____ **DATE** _____

PREVIOUS DENTIST INFORMATION

Dentist: _____ Telephone: _____

Clinic/Facility: _____

Address: _____

_____

CITY ST ZIP CODE

Reason for changing: _____

DENTAL HISTORY

ORAL HEALTH: ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

Date of Last Dental Visit: _____ Treatment Type: _____

☐Y ☐N Are you currently having dental discomfort? If yes, explain: _____

☐Y ☐N Any unhappy/unpleasant dental experiences? If yes, explain: _____

☐Y ☐N Any injuries to mouth/teeth/head? If yes, explain: _____

☐Y ☐N Any missing teeth other than wisdom teeth or orthodontic extractions?

☐Y ☐N Have missing teeth been replaced?

☐Y ☐N Orthodontic appliances now or in the past?

☐Y ☐N Gums bleed when brushing or flossing?

☐Y ☐N Concerned about gum disease? History of gum disease? ☐Y ☐N

☐Y ☐N Any concerns about the appearance of your teeth?

☐Y ☐N Does it hurt to bite or chew?

☐Y ☐N Do you clench or grind your teeth? If so, do you wear a night guard or splint? ☐Y ☐N

☐Y ☐N Do you want to become a regular continuing care patient in our practice?

☐Y ☐N Do you want your mouth properly restored and pain free?

☐Y ☐N Does any type of dental treatment make you nervous? If yes, please explain below:

_____

The most important concerns regarding my dental treatment are:

_____

What factors are most important for your satisfaction with our office?

_____

Any additional concerns/comments?

_____

CHILD/MINOR PATIENTS: PLEASE ANSWER THE FOLLOWING QUESTIONS:

☐Y ☐N Any mouth habits? (thumb sucking, nail biting, mouth breathing, nursing/bottle habits, pacifier, etc.)

_____

☐Y ☐N Any unusual speech habits? If yes, explain: _____

☐Y ☐N Any lost teeth? If yes, list: _____

☐Y ☐N Does the patient receive assistance with brushing and flossing? If yes, how often?

_____

PRIMARY PHYSICIAN INFORMATION

Physician: _____ Telephone: _____

Clinic/Facility: _____

MEDICAL HISTORY

GENERAL HEALTH: ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR

☐ Y ☐ N Under a physician's care now?
☐ Y ☐ N Any hospitalization in the past 5 years?
☐ Y ☐ N Any serious illnesses/surgeries?
☐ Y ☐ N Use tobacco in any form? If Yes, Type:
☐ Y ☐ N Is pre-medication required before dental visits due to heart condition or artificial joint?
☐ Y ☐ N Taking any prescription or daily OTC medications/drugs? If yes, list details in the Medication Section.

FEMALE PATIENTS: ☐ Y ☐ N Currently nursing? ☐ Y ☐ N Currently pregnant? Due Date:

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? ☐ Y ☐ N
If yes, please describe:

Is there anything important about your medical condition we have not asked? ☐ Y ☐ N If yes, please describe:

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐ NONE

☐ ACID REFLUX	☐ BULIMIA	☐ HEARING PROBLEMS	☐ PSYCHIATRIC TREATMENT
☐ ADHD	☐ CANCER/MALIGNANCY	☐ HEART ATTACK	☐ RADIATION/CHEMO
☐ AIDS/HIV	☐ CEREBRAL PALSY	☐ HEART DISEASE	☐ RESPIRATORY DISEASE
☐ ANEMIA	☐ CHEMICAL DEPENDENCY	☐ HEART MURMUR	☐ RHEUMATIC FEVER
☐ ANOREXIA	☐ CHICKEN POX	☐ HEPATITIS	☐ SINUS PROBLEMS
☐ ANXIETY	☐ CONVULSIONS	☐ HIGH BLOOD PRESSURE	☐ STROKE
☐ ARTIFICIAL HEART VALVE	☐ DEPRESSION	☐ KIDNEY DISEASE	☐ THYROID CONDITION
☐ ARTIFICIAL JOINTS	☐ DIABETES	☐ LIVER PROBLEMS	☐ TUBERCULOSIS
☐ ARTHRITIS	☐ DIZZINESS/FAINTING	☐ MITRAL VALVE PROLAPSE	☐ ULCERS
☐ ASTHMA	☐ EPILEPSY/SEIZURES	☐ MONONUCLEOSIS	☐ VENEREAL DISEASE
☐ AUTISM/ASPERGER'S	☐ FREQUENT EAR INFECTIONS	☐ PACEMAKER	
☐ BLEEDING DISORDER	☐ FREQUENT HEADACHES	☐ OTHER – PLEASE LIST:	

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ ASPIRIN	☐ CODEINE	☐ LACTOSE INTOLERANCE	☐ SLEEPING PILLS	☐ NONE
☐ ANESTHETIC – LOCAL	☐ DAIRY	☐ METAL SENSITIVITY	☐ SULFA DRUGS	
☐ BARBITURATES	☐ LATEX	☐ NITROUS OXIDE SEDATION	☐ PENICILLIN/OTHER ANTIBIOTICS	
☐ OTHER – PLEASE LIST:				

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐ NONE

☐ ANTIBIOTICS/SULFA DRUGS	☐ ANTIHISTAMINES/ALLERGY	☐ DAILY ASPIRIN	☐ BLOOD PRESSURE MEDICATIONS
☐ BLOOD THINNERS	☐ CANCER/CHEMO MEDICATIONS	☐ CORTISONE/STEROIDS	☐ HEART MEDICATION/DIGITALIS
☐ INSULIN	☐ NITROGLYCERIN	☐ ORAL CONTRACEPTIVES	☐ OSTEOPOROSIS MEDICATIONS
☐ OTHER DIABETIC MEDICATIONS	☐ RECREATIONAL DRUGS	☐ THYROID MEDICATIONS	☐ TRANQUILIZERS
☐ OTHER (PLEASE LIST BELOW)			

DRUG NAME	DOSAGE	REASON PRESCRIBED