DENTAL HEALTH HISTORY

Today's Date ______________________

Patient Name ________________________________ Birthdate ______________ SS# ______________
Last First Initial

Address ____
City ZIP

Home Phone # ________________ Cell # ________________ Email ________________

Insurance ________________________ ID# ______________ Group # ______________

Employer ________________________ Empl. Address
____

DENTAL HISTORY

Reason for Today's Visit ________________________ Date of Last Cleaning ______________
Former Dentist ________________________ Date of Last Xrays ______________
Former Dentist phone # ________________ Location ________________________
Check (✔) if you have had problems with any of the following:

- ▢ Bad Breath
- ▢ Grinding teeth
- ▢ Sensitivity to Sweets
- ▢ Bleeding gums
- ▢ Loose Teeth or broken fillings
- ▢ Sensitivity when biting
- ▢ Clicking or popping jaw
- ▢ Periodontal treatment
- ▢ Sores or growths in your mouth
- ▢ Food Collection between teeth
- ▢ Sensitivity to hot or cold

How often do you brush?________________ How often do you floss? ________________

MEDICAL HISTORY

Physician's Name ________________________ Date of Last Visit ______________
Have you had any serious illnesses or operations? ________ If yes, please describe ________________
____

Have you ever taken Fen-Phen?Redux? ____________
(Women) Are you currently pregnant? ______ Nursing? ______ Taking birth control pills? ______
Check (✔) if you have or have had any of the following:

- ▢ Anemia
- ▢ Arthritis, Rheumatism
- ▢ Artificial Heart Valves
- ▢ Artificial Joints
- ▢ Asthma
- ▢ Back Problems
- ▢ Blood Disease
- ▢ Cancer
- ▢ Chemical Dependency
- ▢ Chemotherapy
- ▢ Circulatory Problems
- ▢ Cortisone Treatments
- ▢ Cough, Persistent
- ▢ Cough up Blood
- ▢ Diabetes
- ▢ Epilepsy
- ▢ Fainting
- ▢ Glaucoma
- ▢ Heart Murmur
- ▢ Heart Problem
- ▢ Hemophilia
- ▢ Hepatitis
- ▢ High Blood Pressure
- ▢ HIV/AIDS
- ▢ Jaw Pain
- ▢ Kidney Disease
- ▢ Liver Disease
- ▢ Mitral Valve Prolapse
- ▢ Pacemaker
- ▢ Radiation Treatment
- ▢ Respiratory Disease
- ▢ Rheumatic Fever
- ▢ Shortness of Breath
- ▢ Stroke
- ▢ Swelling of Feet or Ankles
- ▢ Thyroid Problems
- ▢ Tobacco Habit
- ▢ Tuberculosis
- ▢ Ulcer

Medications

List all medications you are currently taking:
____
____
____

Allergies

- ▢ Aspirin
- ▢ Codeine
- ▢ Local Anesthetic
- ▢ Other ________________________
- ▢ Sulfa
- ▢ Latex
- ▢ Penicillin

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date ________________ **Signature** ________________________________