

## DENTAL HISTORY

Please check any of the following problems that apply to you.

- Sensitivity (hot, cold, sweet)
- Tooth pain or discomfort when chewing
- Headaches, earaches, neck pain
- Jaw Joint Pain
- Teeth or fillings breaking
- Grinding or clenching teeth
- Bleeding, swollen or irritated gums
- Loose, tipped or shifting teeth
- Bad breath or bad taste in your mouth
- Cold or canker sores

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

- Dentures: Full or Partial
- Oral Surgery
- Braces
- Periodontal (gum) treatments
- Root Canal Therapy

Please share the following dates:

- Your last cleaning \_\_\_\_\_
- Your last oral cancer screening \_\_\_\_\_
- Your last complete X-rays \_\_\_\_\_

Name of Previous Dentist

City: \_\_\_\_\_ Phone: \_\_\_\_\_

How can we improve on your previous dental experiences? \_\_\_\_\_

If you could change your smile, you would:

- Make them brighter
- Make them straighter
- Repair chipped teeth
- Close spaces
- Replace black metal fillings with natural tooth-coloured fillings
- Replace missing teeth
- Replace old crowns that don't match
- Have a smile makeover

What is the most important thing to you about your dental visit today? \_\_\_\_\_

What is the most important thing to you about your future smile and dental health? \_\_\_\_\_

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

## HEALTH HISTORY

Please read & check any of the following that apply to you:

- |   |  |
|---|--|
| <input type="checkbox"/> Allergies (seasonal)   | <input type="checkbox"/> High/Low Blood Pressure |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> HIV Positive            |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Jaw Joint Pain          |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Kidney Disease          |
| <input type="checkbox"/> Artificial Joints      | <input type="checkbox"/> Liver Disease/Jaundice  |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Mitral Valve Prolapse   |
| <input type="checkbox"/> Blood Disease          | <input type="checkbox"/> Nervousness/Depression  |
| <input type="checkbox"/> Bruise Easily          | <input type="checkbox"/> Pacemaker               |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Pregnant Currently      |
| <input type="checkbox"/> Chemotherapy           | <input type="checkbox"/> Radiation (head/neck)   |
| <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Respiratory Problems    |
| <input type="checkbox"/> Dizziness              | <input type="checkbox"/> Rheumatic Fever         |
| <input type="checkbox"/> Drug Addiction         | <input type="checkbox"/> Rheumatism              |
| <input type="checkbox"/> Emphysema              | <input type="checkbox"/> Scarlet Fever           |
| <input type="checkbox"/> Excessive Bleeding     | <input type="checkbox"/> Seizures                |
| <input type="checkbox"/> Fainting               | <input type="checkbox"/> Sinus Problems          |
| <input type="checkbox"/> Glaucoma               | <input type="checkbox"/> Stomach Problems        |
| <input type="checkbox"/> Heart Conditions       | <input type="checkbox"/> Stroke                  |
| <input type="checkbox"/> Heart Lesions          | <input type="checkbox"/> Thyroid Disease         |
| <input type="checkbox"/> Heart Murmur           | <input type="checkbox"/> Tuberculosis            |
| <input type="checkbox"/> Heart Surgery          | <input type="checkbox"/> Ulcers                  |
| <input type="checkbox"/> Hepatitis A B C        | <input type="checkbox"/> Venereal/STD Diseases   |
| <input type="checkbox"/> Other: _____           |  |

Do you have any of the following allergies?

- |  |                                       |
|--|---------------------------------------|
| <input type="checkbox"/> Aspirin       | <input type="checkbox"/> Codeine      |
| <input type="checkbox"/> Latex         | <input type="checkbox"/> Erythromycin |
| <input type="checkbox"/> metal/jewelry | <input type="checkbox"/> Penicillin   |
| <input type="checkbox"/> Sulfa         | <input type="checkbox"/> Other: _____ |

Have you ever been instructed to take antibiotics prior to dental care? \_\_\_\_\_

Are you under a physicians's care? What for? \_\_\_\_\_

Are you taking any medications? \_\_\_\_\_

I allow my medical doctor to be consulted if necessary.

Physician's Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

*The above personal, dental, and medical history is complete and accurate, and I have not knowingly withheld information. I authorize the dentist to perform diagnostic procedures and administer treatment. I will be presented options and allowed to ask questions. I understand that responsibility for payment for all procedcures during treatment is mine.*

Signed \_\_\_\_\_

Dated \_\_\_\_\_

Dr. Initials \_\_\_\_\_