Dental and Health History

Confidential

Today's Date: _____

Patient Name: _____ Birth date:_____

DENTAL HISTORY

Reason for Today's visit_____ Date of last dental care _____

Former Dentist _____ Date of last dental x-rays _____

Address _____

Mark (X) if you have had problems with any of the following:

___Bad Breath	___Grinding teeth	___Sensitivity to hot
___Bleeding Gums	___Loose teeth	___Sensitivity to sweets
___Clicking or popping jaw	___Periodontal treatment	___Sensitivity to biting
___Food collection between teeth	___Broken fillings	___Sensitivity to cold
___Sore/growths in your mouth	___Previous orthodontics(braces)	

How often do you brush?_____ How often do you floss?_____

Have you been taught how to control dental Plaque? _____ Special devices used: _____

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Have you had any serious illnesses or operations? _____if yes, please describe _____

_____

Mark (X) if you have or have had any of the following:

___Anemia	___Cortisone treatments	___High Blood Pressure	___Shortness of Breath
___Arthritis	___Cough	___HIV/AIDS	___Sinus problems
___Artificial heart valve	___Diabetes	___Jaw Pain	___Skin Condition
___Artificial Joints	___Epilepsy	___Kidney Disease	___Stomach Problems
___Asthma	___Headaches	___Mitral Valve Prolapse	___Stroke
___Bleeding Disorder	___Heart Murmur	___Pacemaker	___Thyroid Problem
___Cancer	___Heart Problems	___Pregnant	___Tobacco Use
___Chemical Dependency	___Hemophilia	___Radiation	___Ulcer
___Chemotherapy	___Hepatitis	___Rheumatic Fever	___Other

MEDICATIONS

List Medications Currently Taking:

_____

_____

Pharmacy Name: _____

Pharmacy Phone: _____

ALLERGIES

___Aspirin ___Penicillin ___Other_____

___Codeine ___Sulfa _____

___Novocain ___Latex

Medical/Dental Hx Reviewed: _____

SIGNATURE

I understand all of the above information is necessary to provide me with dental care in a safe and efficient manner. To the best of my knowledge, the above information is complete and correct. I also understand that it is my responsibility to inform the staff of any changes in my or my minor child's health.

Patient, Parent, or Personal Representative Signature: _____ Date:_____