Patient Name	
Patient Account No.	Medical Alert

DENTAL HISTORY

WELCOME!! *So that we may provide you with the best possible care, please complete both sides of this medical/ dental history form. All information is completely confidential.*

What is the reason for your visit today? ______________________________

____

If you were able to change anything about your smile, what would you change? ______________________________

____

Date of last Dental Visit ____________ **Last Dental Cleaning** ____________ **Last Full Mouth X-rays** ________

What was done at your last dental visit? ______________________________

Previous Dentist's Name ______________________ State ____________ Zip ________

Address ______________________________ Telephone (_____) ____________

How often do you have dental examinations? ______________________________

How often do you brush your teeth?________________ How often do you floss? ____________

What other dental aids do you use? (Hydrofloss, Electric Toothbrush, Toothpick) ____________

Do you have dental problems? Yes No If yes, please describe: ____________

____

Please circle the correct response to:

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or lesions?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease of tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to get caught between your teeth?	Yes	No

If so, where?

____

Do you clench or grind your teeth?	Yes	No
Do you bite your lips or cheeks regularly?	Yes	No
Do you hold foreign objects in your teeth?	Yes	No
Do you bite your nails?	Yes	No
Do you mouth breathe while awake or asleep?	Yes	No
Do you smoke or chew tobacco?	Yes	No

Have you had orthodontic treatment?	Yes	No
Have you had oral surgery?	Yes	No
Have you had periodontal treatment?	Yes	No
Have you had your bite adjusted?	Yes	No
Have you had a mouth guard or bite plate?	Yes	No
Have you had a serious head or mouth injury?	Yes	No

If so, please describe, including cause:

____

Have you experienced clicking or popping?	Yes	No
Have you experienced pain (joint, ear, face)?	Yes	No
Have you had difficulty chewing?	Yes	No
Have you had headaches or neckaches?	Yes	No
Have you had shoulder aches or muscle aches?	Yes	No
Are you satisfied with your teeth's appearance?	Yes	No
Would you like to keep your teeth for life?	Yes	No
Do you feel nervous about dental treatment?	Yes	No

If so, what is your biggest concern?

____

Have you ever had an upsetting dental experience? Yes No

If so, please describe:

____

Is there anything else about having dental treatment that you would like us to know about? Yes No

If yes, please describe: ______________________________

____

(Please complete the other side)

Patient Name	**MEDICAL HISTORY**
Patient Account No.	Medical Alert

1. Have you been under the care of a medical doctor during the past two years? Yes No
   If yes, for what? ______
   Physician's Name: ______ Phone: (____)______
   Address: ______ City: ______ State:____ Zip:______
2. Have you taken any medication or drugs the past two years? Yes No
3. Are you taking any medication, drugs or pills now? Yes No
   If yes, please list the name and dosage: ______
4. Have you ever taken prescription medications for weight loss (diet pills)? Yes No
   If yes, did you take any of the following: Fen-Phen (Fenfluramine-Phenopermine) Yes No
   Pondimen (Fenfluramine) Yes No
   Redux (Desfenfluramine) Yes No
   If yes to any of the above, did you have a medical exam for heart issues? Yes No
5. Are you aware of having an allergic (or adverse reaction) to any medication or substance? Yes No
   If yes, please list: ______
6. Have you been a patient in the hospital during the past five years? Yes No
7. Indicate which of the following you have had, or have at present. Circle "Yes" or "No" for each:

Heart (surgery, disease, attack):	Yes	No	*Ulcers:*	Yes	No	*Hepatitis A or B:*	Yes	No
Chest Pain:	Yes	No	*Diabetes:*	Yes	No	*Venereal Disease:*	Yes	No
Congenital Heart Disease:	Yes	No	*Thyroid Problems:*	Yes	No	*A.I.D.S.:*	Yes	No
Heart Murmur:	Yes	No	*Glaucoma:*	Yes	No	*H.I.V. Positive:*	Yes	No
High Blood Pressure:	Yes	No	*Contact Lenses:*	Yes	No	*Cold Sores/Blisters:*	Yes	No
Mitral Valve Prolapse:	Yes	No	*Emphysema:*	Yes	No	*Blood Transfusion:*	Yes	No
Artificial Heart Valve:	Yes	No	*Chronic Cough:*	Yes	No	*Hemophilia:*	Yes	No
Heart Pacemaker:	Yes	No	*Tuberculosis:*	Yes	No	*Sickle Cell Disease:*	Yes	No
Rheumatic Fever:	Yes	No	*Asthma:*	Yes	No	*Bruise Easily:*	Yes	No
Arthritis/Rheumatism:	Yes	No	*Hay Fever:*	Yes	No	*Liver Disease:*	Yes	No
Cortisone Medicine:	Yes	No	*Latex Sensitivity:*	Yes	No	*Yellow Jaundice:*	Yes	No
Swollen Ankles:	Yes	No	*Allergies or Hives:*	Yes	No	*Neurological Disorder:*	Yes	No
Stroke:	Yes	No	*Sinus Trouble:*	Yes	No	*Epilepsy/Seizures:*	Yes	No
Diet (special/restricted):	Yes	No	*Radiation Therapy:*	Yes	No	*Fainting/Dizzy Spells:*	Yes	No
Artificial Joints (hip/knee):	Yes	No	*Chemotherapy:*	Yes	No	*Nervous/Anxious*	Yes	No
Kidney Trouble:	Yes	No	*Tumors:*	Yes	No	*Psychiatric Care:*	Yes	No

8. Do you use more than two pillows to sleep? Yes No
9. Have you lost or gained more than 10 pounds in the past year? Yes No
10. Do you have or have you had any disease, condition, or problem not listed? Yes No
    If yes, please list: ______
11. **Women**, are you? **Pregnant** Yes____months No **Nursing**? Yes No **ıking birth control pills**? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, you may release such information to you.

I will notify the dentist of any change in my health or medication.

I have been given the opportunity to read and review the Federal (HIPAA - Health Insurance Portability and Accountability Act). Other than is stated by the act or where Federal State or Local law requires, my health information will not be disclosed without further written authorization. I may revoke this authorization in writing at any time.

Initial ______

Patient/Guardian Signature: ______ Date: ______

History Review

Dentist Signature: ______ Date: ______