DENTAL HEALTH RECORDS

When was your last dental visit? _____

How often did you see your dentist? _____

Are you having any problems that require immediate attention? _____

Do any of the following cause tooth discomfort? Hot? ☐ Cold? ☐ Sweets? ☐ Chewing? ☐

How often do you brush your teeth? _____ Floss? _____ Water Jet? _____

Do your gums bleed while cleaning? _____

Do your gums ever feel tender or swollen? _____

Have you had periodontal treatment? _____ When? _____

Are you ever aware that you clench or grind your teeth? _____

Do your jaws ever feel tired or ache? _____ Click or pop? _____

Do you chew on both sides of your mouth _____ Comfortably? _____

Do you have frequent headaches _____ Earaches? _____

Have you ever had orthodontic treatment (Braces)? _____ When? _____

Do you usually have many cavities? _____

Do you have any loose teeth? _____ Cracked or broken teeth? _____

Do you have noticeable wear on your teeth? _____ Food traps? _____

Do you have any missing teeth? _____ Have they been replaced? _____

If so, how and when? Fixed bridge? _____ Removable partial? _____

Full denture? _____ Implants? _____

Are you comfortable with the replacement? _____ Please describe _____

_____

_____

How do you feel about the appearance of your smile? _____

Have you ever had any cosmetic dentistry done to improve your appearance? _____

If yes, are you pleased with the result? _____ Please comment _____

_____

Have you ever had an unpleasant dental experience? _____

_____

Would you like to receive information about any of these dental services:

Bleaching _____ Porcelain veneers _____

Implants _____ Bonding _____

Please add anything you feel is important? _____

_____

_____

_____

Patient Signature _____ Staff initials _____

(Parent of Guardian) Signature _____

PATIENT HEALTH RECORD

(Please Print)

Date _____ Date of Birth _____

Name M _____ Spouses Name _____

If Child; Parent or Guardian's Name _____

Home Phone _____ Best Time to Call _____

Home Address, City & Zip _____

Employed by _____ Occupation _____

May we call you at work? _____ Yes _____ No Business Phone _____

Dental Insurance _____ Yes _____ No Social Security No. _____

Driver's License No. (If paying by check) _____

Whom may we thank for referring you to us? _____

MEDICAL HEALTH

Physician's Name _____ Phone No. _____

Address _____ Date of Last Physical _____

Current Medicines you are taking. (Please List) _____

_____

Have you been under a physicians care during the past 2 years? _____

For? _____

Have you had a major illness, surgery or hospitalization during the past 2 years? _____

For? _____

Allergies? (Please List) _____

*Please indicate whether or not you have previously had or have at present **any** of the following:*

Abnormal blood pressure	_____ Yes	_____ No	Hepatitis Type _____	_____ Yes	_____ No
AIDS / HIV	_____ Yes	_____ No	Herpes	_____ Yes	_____ No
Anemia	_____ Yes	_____ No	Jaundice	_____ Yes	_____ No
Angina	_____ Yes	_____ No	Kidney disease	_____ Yes	_____ No
Arthritis	_____ Yes	_____ No	Liver disease	_____ Yes	_____ No
Artificial heart valve	_____ Yes	_____ No	Organ transplant	_____ Yes	_____ No
Artificial joints	_____ Yes	_____ No	Pacemaker	_____ Yes	_____ No
Asthma	_____ Yes	_____ No	Prolonged bleeding	_____ Yes	_____ No
Blood transfusion	_____ Yes	_____ No	Prolonged cough	_____ Yes	_____ No
Cancer	_____ Yes	_____ No	Psychiatric treatment	_____ Yes	_____ No
Chemotherapy	_____ Yes	_____ No	Radiation therapy	_____ Yes	_____ No
Congenital heart lesions	_____ Yes	_____ No	Rheumatic fever	_____ Yes	_____ No
Diabetes	_____ Yes	_____ No	Stroke	_____ Yes	_____ No
Drug / Alcohol dependency	_____ Yes	_____ No	Thyroid disease	_____ Yes	_____ No
Epilepsy / Seizures	_____ Yes	_____ No	Tuberculosis	_____ Yes	_____ No
Fainting	_____ Yes	_____ No	Ulcers	_____ Yes	_____ No
Glaucoma	_____ Yes	_____ No	Venereal disease	_____ Yes	_____ No
Heart / Lung disease	_____ Yes	_____ No	Do you use tobacco?	_____ Yes	_____ No
Heart murmur / MVP	_____ Yes	_____ No	Other, not Listed _____		

Have you ever been given an antibiotic prior to dental treatment: _____

Do you become short of breath after little exertion? _____

For Women:

Are you pregnant? _____ Yes _____ No. If yes, what month? _____ Nursing? _____ Yes _____ No.

Are you taking hormones or birth control? _____

OVER PLEASE