**Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.**

Patient name: _____ Date of birth: _____
Sex: _____ Age: _____
Home address: _____ City: _____ State: _____
Zip: _____
Billing address (if different): _____ City: _____ State: _____ Zip: _____
Home phone: _____ Cell: _____ E-mail: _____ Driver's license #: _____ State: _____
SS #: _____ Employer/Occupation: _____ Bus. Phone: _____
Spouse's name & phone #: _____ Emergency phone # (other than spouse): _____
Primary dental insurance: _____ Group #: _____
Secondary dental insurance: _____ Group #: _____
Subscriber's name: _____ Date of birth: _____ SS #: _____
Name of your medical doctor: _____ Date of last visit to medical doctor: _____
Name of previous dentist: _____ Date of last visit to dentist: _____
Referred to us by: _____
_____

## DENTAL HEALTH HISTORY

**Yes No**

How often do you brush? _____
How often do you floss? _____
Does your jaw make noise so that it bothers you or others? _____
Do you clench or grind your jaws frequently? _____
Do your jaws ever feel tired? _____
Does your jaw get stuck so that you can't open freely? ____
Does it hurt when you chew or open wide to take a bite? __
Do you have earaches or pain in front of the ears? _____
Do you have any jaw symptoms or headaches upon awaking in the morning? _____
Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities? _____
Do you find jaw pain or discomfort extremely frustrating or depressing? _____
Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)? _____
Do you have a temporomandibular (jaw) disorder (TMD)? _____
Do you have pain in the face, cheeks, jaws, joints, throat, or temples? _____
Are you unable to open your mouth as far as you want? ___
Are you aware of an uncomfortable bite? _____
Have you had a blow to the jaw (trauma)? _____
Are you a habitual gum chewer or pipe smoker? _____
Are you apprehensive about dental treatment? _____
Have you had problems with previous dental treatment? __
Do you gag easily? _____

Do you wear dentures? _____

Does food catch between your teeth? _____

Do you have difficulty in chewing your food? _____

Do you chew on only one side of your mouth? _____
Do you avoid brushing any part of your mouth

because of pain? _____

Do your gums bleed easily? _____

Do your gums bleed when you floss? _____

Do your gums feel swollen or tender? _____
Have you ever noticed slow-healing sores in or

about your mouth? _____

Are your teeth sensitive? _____
Do you feel twinges of pain when your teeth come in contact with:

Hot foods or liquids? _____

Cold foods or liquids? _____

Sours? _____

Sweets? _____

Do you take fluoride supplements? _____

Are you dissatisfied with the appearance of your teeth? ____

Do you prefer to save your teeth? _____

Do you want complete dental care? _____

# MEDICAL HEALTH HISTORY:

**Do you have, or have you had, any of the following? (Yes No)**

Diabetes _____

Urinate more than 6 times a day _____

Thirsty or mouth is dry much of the time

Family history of diabetes _____

Tuberculosis or other respiratory disease ____

Do you drink alcohol? _____
If so, how much? _____

Do you smoke? _____
If so, how much? _____

Hepatitis, jaundice, or liver trouble _____

Herpes or other STD _____

HIV-positive/AIDS _____

Glaucoma _____

Do you wear contact lenses? _____

History of head injury? _____

Epilepsy or other neurological disease? ____

History of alcohol or drug abuse? _____
Do you have any disease, condition, or problem not listed previously that you feel we should know about?
If so, please describe: _____

**During the past 12 months, have you taken any of the following? Yes No**

**Antibiotics or sulfa drugs**

**Anticoagulants (e.g., Coumadin)**

**High blood pressure medicine**

**Tranquilizers**

**Insulin, Orinase, or similar drug**

**Aspirin**

**Digitalis or drugs for heart trouble**

**Nitroglycerin**

**Cortisone (steroids)**

**Natural remedies**

**Nonprescription drug/supplements**
**Other** _____

_____

**Women Yes No**
**Are you taking contraceptives or**

**other hormones?**

**Are you pregnant?**
**If so, expected delivery date:** _____

**Are you nursing?**

**Have you reached menopause?**
**If so, do you have any symptoms?** _____

_____



**Yes No**

Heart Problems _____

Chest pain _____

Shortness of breath _____

Blood pressure problem _____

Heart murmur _____

Heart valve problem _____

Taking heart medication _____

Rheumatic fever _____

Pacemaker _____

Artifi cial heart valve _____

Blood Problems _____

Easy bruising _____

Frequent nosebleeds _____

Abnormal bleeding _____

Blood disease (anemia) _____

Ever require a blood transfusion? _____

Allergy Problems _____

Hay fever _____

Sinus problems _____

Skin rashes _____

Taking allergy medication _____

Asthma _____

Intestinal Problems _____

Ulcers _____

Weight gain or loss _____

Special diet _____

Constipation/Diarrhea _____

Kidney or bladder problems _____

Bone or Joint Problems _____

Arthritis _____

Back or neck pain _____

Joint replacement _____
(e.g., total hip, pins, or implants)

Fainting Spells, Seizures, or Epilepsy _____

Stroke(s) _____

Frequent or severe headaches _____

Thyroid problems _____

Persistent cough or swollen glands _____

**Premedications required by physician** _____

Cancer/Tumor _____

**Are you allergic, or have you reacted adversely, to any of the following? Yes No**

**Local anesthetics ("Novocaine")**

**Penicillin or other antibiotics**

**Sulfa drugs**

**Barbiturates, sedatives, or sleeping pills**

**Aspirin, Acetaminophen, or Ibuprofen**

**Codeine, Demerol, or other narcotics**

**Reaction to metals**

**Latex or rubber dam**

**Other** _____

Notes: _____

Notes: _____

_____

_____ Patient/Parent Signature:

_____

_____ Date: _____ Dentist Initial:

_____