Today's Date _____

Patient Name _____ Birthdate _____
Last First Initial

DENTAL HISTORY

Reason for Today's Visit _____

Former Dentist _____

Address _____

Date of last dental care _____ Date of last dental X-rays _____

Check (✓) if you have had problems with any of the following

- ❒ Bad Breath
- ❒ Bleeding gums
- ❒ Clicking or popping jaw
- ❒ Food collection between teeth
- ❒ Grinding teeth
- ❒ Loose teeth or broken fillings
- ❒ Periodontal treatment
- ❒ Sensitivity to cold
- ❒ Sensitivity to hot
- ❒ Sensitivity to sweets
- ❒ Sensitivity when biting
- ❒ Sores or growths in your mouth

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

MEDICAL HISTORY

Physicians Name _____ Date of Last Visit _____

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

Have you ever had a blood transfusion? ❒ Yes ❒ No If yes, give approximate dates _____

Do you take or have you ever taken Phen-Phen/Redux? ❒ Yes ❒ No

(Women) Are you pregnant? ❒ Yes ❒ No Nursing? ❒ Yes ❒ No Taking birth control pills? ❒ Yes ❒ No

Check (✓) if you have had problems with any of the following:

	YES	NO		YES	NO		YES	NO		YES	NO
AIDS	❒	❒	Cortisone Treatments	❒	❒	Hepatitis	❒	❒	Rheumatic Fever	❒	❒
Anemia	❒	❒	Cough, Persistent	❒	❒	High Blood Pressure	❒	❒	Scarlet Fever	❒	❒
Arthritis, Rheumatism	❒	❒	Cough up Blood	❒	❒	HIV Positive	❒	❒	Shortness of Breath	❒	❒
Artificial Heart Valves	❒	❒	Diabetes	❒	❒	Jaw Pain	❒	❒	Skin Rash	❒	❒
Artificial Joints	❒	❒	Epilepsy	❒	❒	Kidney Disease	❒	❒	Stroke	❒	❒
Asthma	❒	❒	Fainting	❒	❒	Liver Disease	❒	❒	Swelling of Feet or Ankles	❒	❒
Back Problems	❒	❒	Glaucoma	❒	❒	Mitral Valve Prolapse	❒	❒	Thyroid Problems	❒	❒
Blood Disease	❒	❒	Headaches	❒	❒	Nervous Problems	❒	❒	Tobacco Habit	❒	❒
Cancer	❒	❒	Heart Murmur	❒	❒	Pacemaker	❒	❒	Tonsilitis	❒	❒
Chemical Dependency	❒	❒	Heart Problems	❒	❒	Psychiatric Care	❒	❒	Tuberculosis	❒	❒
Chemotherapy	❒	❒	Describe _____	❒	❒	Radiation Treatment	❒	❒	Ulcer	❒	❒
Circulatory Problems	❒	❒	Hemophilia	❒	❒	Respiratory Disease	❒	❒	Venereal Disease	❒	❒

MEDICATIONS

List medications you are currently taking:

_____

_____

Pharmacy name _____

Phone _____

ALLERGIES

- ❒ Aspirin
- ❒ Barbituates (Sleeping pills)
- ❒ Codeine
- ❒ Local Anesthetic
- ❒ Penicilin
- ❒ Sulfa
- ❒ Latex
- ❒ Latex

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Patient Signature _____ Dr. Signature _____

Date _____ Patient Signature _____ Dr. Signature _____

Date _____ Patient Signature _____ Dr. Signature _____