Patient Name_______________________________________Nickname_______________Age__________
Name of Physician/and their specialty____
Name of Previous Dentist___________________ How long has it been since you were last seen by a Dentist?______

DENTAL HISTORY

How would rate the condition of your mouth? Excellent ☐ Good ☐ Fair ☐ Poor ☐

WHAT IS YOUR IMMEDIATE DENTAL CONCERN?_______________________________________

PLEASE ANSWER YES OR NO TO THE FOLLOWING:	YES	NO
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [___]________	☐	☐
2. Have you ever had trouble getting numb or had any reactions to local anesthetic________	☐	☐
3. Did you ever have braces, orthodontic treatment or had you bite adjusted? ________	☐	☐
4. Is there anything about the appearance of your teeth that you would like to change?________	☐	☐
5. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)________	☐	☐
6. Do you have any problems eating hard foods?________	☐	☐
7. Are your teeth sensitive to hot, cold, biting, sweets? Do you avoid brushing any part of your mouth?________	☐	☐
8. Do you clench or grind your teeth?________	☐	☐
9. Do you wear or have you ever worn a bite appliance?________	☐	☐
10. Do your gums bleed when you brush or floss?________	☐	☐
11. Is there anyone with a history of periodontal disease in your family?________	☐	☐

12. Any additional information you would like the Dentist to know?
Please list____

MEDICAL HISTORY

What is your estimate of your general health? Excellent ☐ Good ☐ Fair ☐ Poor ☐

What conditions are you currently being treated for?_______________________________________

DO YOU HAVE OR HAVE YOU EVER HAD:	YES	NO
▪ An allergic reaction to:	☐	☐
☐ Aspirin, Ibuprofen, acetaminophen, codeine ☐ Penicillin, erythromycin, tetracycline, sulpha** **PLEASE circle**		
☐ Local anesthetic, fluoride, latex, metals (nickel, gold, silver, _______)		
☐ Other________________		
2. Heart problems: heart attack, cardiac by-pass, cardiac stent, pacemaker, defibrillator, history of endocarditis________	☐	☐
3. Artificial joints (i.e. knee, hip) or heart valves________	☐	☐
4. High or low blood pressure, a stroke, TIA________	☐	☐
5. Asthma, emphysema, sarcoidosis, tuberculosis, or any breathing or sleep problems (i.e. snoring, sinus)________	☐	☐
6. Kidney, liver, thyroid, parathyroid disease or jaundice________	☐	☐
7. Diabetes (Type____)________	☐	☐
8. Stomach or duodenal ulcer, digestive disorders (i.e. gastric reflux)________	☐	☐
9. Arthritis, osteoporosis/osteopenia________	☐	☐
10. Cancer, tumor, abnormal growth, chemotherapy, radiation therapy________	☐	☐
11. Hepatitis (type___), venereal disease, HIV/AIDS________	☐	☐
12. Head or neck injuries, epilepsy, convulsions (seizures), neurologic problems________	☐	☐
13. FEMALE --- Are you pregnant________	☐	☐

PLEASE LIST ALL MEDICATIONS, SUPPLEMENTS, AND / OR VITAMINS YOU ARE TAKING

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING

Patient's Signature_______________________________________ Date______________

Doctor's Signature_______________________________________ Date______________