DENTAL HISTORY

Please check any of the following problems that apply to you.				**If you could whiten your teeth for a cost anyone could afford, would you do it?**	☐	
-Sensitivity (hot, cold, sweet) Where? UR LR UL LL	☐			**Do you smoke or use chewing tobacco?** How much? For how long?	☐	
-Headaches, earaches, neck pain	☐			**If I could change my smile, I would:**	☐	
-Jaw joint pain	☐			-Make them whiter	☐	
-Teeth or fillings breaking	☐			-Make them straighter	☐	
-Grinding or clenching teeth	☐			-Close spaces	☐	
-Bleeding, swollen or irritated gums	☐			-Replace black metal fillings with tooth colored restorations	☐	
-Loose, tipped or shifting teeth	☐					
-Bad breath	☐			-Repair chipped teeth	☐	
Do you have or have you had any of the following?				-Replace missing teeth	☐	
				-Replace old crowns that don't match	☐	
-Dentures	☐			-Have a smile makeover	☐	
-Partial dentures	☐			**On a scale of 1 – 10, with 10 being the highest rating:**		
-Braces	☐					
-Periodontal (gum) treatments	☐			-How important is your dental health to you? 1 2 3 4 5 6 7 8 9 10		
Please share the following dates:				-Where would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10		
-Your last cleaning	___ / ___			-Where do you want your dental health to be? 1 2 3 4 5 6 7 8 9 10		
-Your last oral cancer screening	___ / ___					
-Your last complete X-Rays	___ / ___					
Name of Previous Dentist _____						
City _____ **State** _____ **Phone Number** _____				**Why did you leave your previous dentist?** _____		
Have you ever considered Botox or Fillers? _____				**What is the most important thing to you about your dental visit today?** _____		

MEDICAL HISTORY

Please check any of the following that apply to you:

☐ AIDS	☐ Drug Addiction	☐ HIV Positive	☐ Rheumatic Fever
☐ Allergies (Seasonal)	☐ Emphysema	☐ Jaundice	☐ Rheumatism
☐ Anemia	☐ Excessive Bleeding	☐ Jaw Joint Pain	☐ Scarlet Fever
☐ Arthritis	☐ Fainting	☐ Kidney Disease	☐ Seizures
☐ Artificial Heart Valve	☐ Glaucoma	☐ Liver Disease	☐ Stomach Problems
☐ Artificial Joints	☐ Heart Conditions	☐ Low Blood Pressure	☐ Stroke
☐ Asthma	☐ Heart Lesions (Congenital)	☐ Mitral Valve Prolapse	☐ Thyroid Disease
☐ Blood Disease	☐ Heart Murmur	☐ Nervousness/Depression	☐ Tuberculosis
☐ Bruise Easily	☐ Heart Surgery	☐ Pacemaker	☐ Ulcers
☐ Cancer	☐ Hepatitis A	☐ Phen Fen (1 month +)	☐ Snoring
☐ Chemotherapy	☐ Hepatitis B	☐ Pregnant Currently	☐ Other
☐ Diabetes	☐ Hepatitis C	☐ Radiation (head/neck)	☐ CPAP
☐ Dizziness	☐ High Blood Pressure	☐ Respiratory Problems	☐ Sleep Apnea

Do you have any of the following drug allergies?		**Are you under a physician's care? What for?**
☐ Aspirin	☐ Codeine	_____
☐ Darvon	☐ Erythromycin	**Are you taking any medications? What?**
☐ Nitrous Oxide	☐ Latex	_____
☐ Percodan	☐ Penicillin	**Family Physician** **Phone Number**
☐ Local Anesthetic	☐ Sulfa	_____ _____
☐ Tetracycline	☐ Other	

Patient Signature (guardian) _____ Date_____