DENTAL HISTORY

Please check any of the following that apply to you.

- ☐ Currently experiencing dental pain/discomfort
- ☐ Sensitivity to cold, heat or sweets
  If yes, where? UR LR UL LL
- ☐ Headaches, earaches, neck pain
- ☐ Jaw joint pain
- ☐ Teeth or filling breaking
- ☐ Grinding or clenching of teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, tipped or shifting teeth
- ☐ Bad breath.

Do you have or have you had any of the following?

- ☐ Dentures
- ☐ Partial dentures
- ☐ Braces
- ☐ Periodontal (gum) treatments

Please share the following dates:

Your last dental cleaning _____/_____
Your last oral cancer screening _____/_____
Your last complete X-rays _____/_____

Name of Previous Dentist: _____
Why did you leave? _____
What did you like *most* about your last dentist? _____
_____

If you could whiten your teeth for a cost anyone could afford, would you do it? Y N

Do you smoke or use chewing tobacco? Y N
How much? How long?

If I could change my smile, I would:

- ☐ Make them whiter
- ☐ Make them straighter
- ☐ Close spaces
- ☐ Replace black metal fillings with tooth colored restorations
- ☐ Repair chipped teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover

On a scale from 1 ---- 10, with 10 being the highest rating:

How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

Where do you want your dental health to be?
1 2 3 4 5 6 7 8 9 10

What is your most important question or concern about your dental visit today?

MEDICAL HISTORY

Please check any of the following that apply to you.

- ☐ Abnormal Bleeding
- ☐ Alcohol Abuse
- ☐ Allergies
- ☐ Anemia
- ☐ Angina Pectoris
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chlamydia
- ☐ Chemotherapy
- ☐ Colitis
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Drug Abuse
- ☐ Emphysema
- ☐ Excessive Bleeding
- ☐ Facial Surgery
- ☐ Fainting Spells
- ☐ Fever Blisters
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Gonorrhea
- ☐ HIV/AIDS
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Jaw Joint Pain
- ☐ Jaundice
- ☐ Joint Replacement
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pace Maker
- ☐ Pregnant (Currently)
- ☐ Psychiatric Problems
- ☐ Radiation Thearpy
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sexually Transmitted Disease
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Syhpilis
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers

Do you have any of the following drug allergies?

- ☐ Aspirin
- ☐ Nitrous Oxide
- ☐ Percodan
- ☐ Local Anesthetic
- ☐ Tetracycline
- ☐ Codeine
- ☐ Erthromycin
- ☐ Valium
- ☐ Penicillin
- ☐ Sulfa
- ☐ Latex
- ☐ Other: _____

Are you in currently under the care of a physician? If yes, explain.
_____
Physician's Name: _____
Phone: _____
Please list any medications you are currently taking:
_____

Treatment Authorization Form

I hereby authorize and give consent to perform dental services agreed upon between doctor and patient and/or parent or guardian, after thorough explanation and to be necessary and advisable, including any diagnostic aids deemed appropriate by the doctor and the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my dental health and medical condition. Payment for all services rendered are my responsibility.

Signature (Patient, Parent or Responsible Party): _____ Relationship to Patient: _____ Date: _____