Name _____ Birthdate _____

Health and Dental History

The following confidential information is important for us in planning your dental care. Please answer each question completely.

1. How long since your last dental visit? _____ X-rays taken _____
2. Have you ever had an upsetting experience in the dental office? ❑ Yes ❑ No
3. How often do you have your teeth cleaned/examined? _____
4. Are your teeth sensitive to: Hot ❑ Cold ❑ Sweets ❑ Pressure ❑ Chewing ❑
   Other _____

Comments _____

5. Have you been informed of or do you have any signs of gum disease, bleeding, odor or aches? When/Where _____
6. Has fear kept you from regular dental care? ❑ Yes ❑ No Explain: _____
7. Are you aware of any swelling or fractured teeth in your mouth? ❑ Yes ❑ No
8. If you could change anything about your teeth, what changes would you make?
9. Do you take pre-medication for dental treatment? ❑ Yes ❑ No If so for what reason?
10. What prompted you to seek dental treatment at this time?

Medical History

1. Name of your physician _____ Phone Number _____
2. Location of your physician _____
3. Are you presently being treated for any medical condition? _____
4. Are you allergic to any medications? _____ None ❑
5. Have you ever had a serious illness? Please explain: _____
6. What medications and dosages are you currently taking? _____
7. Are you taking any blood thinners? ❑ Yes ❑ No _____ *Write additional medications on reverse side*
8. Tobacco use? ❑ Yes ❑ No Type of tobacco: _____ How long?: _____
9. (Women) Are you pregnant? ❑ Yes ❑ No
10. Do you have, or have you ever had?:

Emergency Contact:
Name _____ Phone: _____

Yes	No		Yes	No		Yes	No	
❑	❑	High Blood Pressure	❑	❑	Mental Health Care	❑	❑	Tonsillitis
❑	❑	Mitral Valve Prolapse	❑	❑	Chemical Dependency	❑	❑	Sinus Trouble
❑	❑	Congenital Heart Defect	❑	❑	AIDS/HIV Positive	❑	❑	Tuberculosis or Lung Disease
❑	❑	Heart Murmur	❑	❑	Epilepsy	❑	❑	Diabetes
❑	❑	Heart Disease	❑	❑	Fainting Spells	❑	❑	Thyroid Problems
❑	❑	Circulatory Problems	❑	❑	Tumors/Cancer	❑	❑	Kidney Problems
❑	❑	Rheumatic Fever	❑	❑	Radiation Therapy	❑	❑	Jaundice
❑	❑	Blood Transfusion	❑	❑	Arthritis	❑	❑	Hepatitis
❑	❑	Stroke	❑	❑	Asthma or Hay Fever	❑	❑	Ulcers
❑	❑	Joint Replacement	❑	❑	Other _____	❑	❑	Other _____
❑	❑	Anemia	❑	❑	Other _____	❑	❑	Other _____

Signature: _____ Date: _____