

# Dental History

Name: \_\_\_\_\_

Date: \_\_\_\_\_

- YES NO Are you presently in any dental pain? Explain: \_\_\_\_\_
- YES NO Do you have any pain due to hot, cold, or sweets? Where? \_\_\_\_\_
- YES NO Do you have any pain in any part of your mouth or in any tooth while biting or chewing? Where? \_\_\_\_\_
- YES NO Does food catch between your teeth? Where? \_\_\_\_\_
- YES NO Do your gums bleed while brushing, flossing, chewing, or at any other time? When? \_\_\_\_\_
- YES NO Do you chew on both sides of your mouth? If not, why? \_\_\_\_\_
- YES NO Do you have a tired feeling in your mouth or face after chewing or upon waking up in the morning?
- YES NO Have you had orthodontics? If so, when were the braces removed? \_\_\_\_\_
- YES NO Do you have any missing teeth? If so, how long have they been missing? \_\_\_\_\_ Why did you not have them replaced? \_\_\_\_\_ Was it suggested to have them replaced? \_\_\_\_\_
- YES NO Do your gums feel irritated, tender, or swollen? Where? \_\_\_\_\_
- YES NO Do you avoid brushing any part of your mouth? \_\_\_\_\_ Do you brush lightly or vigorously? \_\_\_\_\_ How often do you brush? \_\_\_\_\_ Floss? \_\_\_\_\_
- YES NO Do you have an unpleasant odor or taste in your mouth?
- YES NO Do you clench or grind your teeth; Has anyone made you aware you clench or grind?
- YES NO Do you understand the meaning of "traumatic occlusion"?
- YES NO Do you visit the dentist regularly? Date of last dental visit? \_\_\_\_\_ Exam/Cleaning? \_\_\_\_\_ X-rays of all your teeth? \_\_\_\_\_
- YES NO Have you ever had a reaction to, or any problems with a dental anesthetic?
- YES NO Are you aware of your jaw clicking, or popping while eating or yawning? How often? \_\_\_\_\_
- YES NO Do you have headaches, neck aches, chronic neck or shoulder pain? If so, where? \_\_\_\_\_
- YES NO Do you have any growths or swellings in your mouth? Where? \_\_\_\_\_
- YES NO Do you have trouble with canker sores or fever blisters?
- YES NO Do you know that decay and gum disease can occur without your being aware of it?

On a scale of 1 to 10, with 10 being the most, how important is it for you to keep your teeth? \_\_\_\_\_

Are you health oriented? **YES NO** What do you do to maintain your overall health? \_\_\_\_\_

Do you consider your mouth to have [ ] Active or [ ] Controlled dental disease?

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Doctor Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Hygienist Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# Health History

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date: \_\_\_\_\_

Your medical history is an integral part of how we treat you. Your mouth and your body act and react together. Diseases and medications you may think are not important to us, can affect the course of treatment. Please answer all questions accurately so we can provide the best care possible. Thank You.

Has there been any problem in your general health within the past 5 years? (Serious illness, hospitalization, surgery, etc.)

**No Yes**, explain \_\_\_\_\_

Any form of cancer? **No Yes**, type or name. When diagnosed? \_\_\_\_\_

Date of last physical \_\_\_\_\_ Physician \_\_\_\_\_

Are you under the care of a physician? **No Yes**, for what condition \_\_\_\_\_

Please list any medications, or supplements you take: \_\_\_\_\_

Does your physician require you take any medication prior to having dental work done? **No Yes**, explain \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Address: \_\_\_\_\_

## DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS?

YES NO Allergies	YES NO Hypoglycemia
YES NO Anorexia	YES NO Hypothyroid
YES NO Are you an alcoholic	YES NO Kidney disease
YES NO Arthritis: Rheumatoid Osteoarthritis	YES NO Liver disease, jaundice
YES NO Artificial Joints, Date Placed: _____	YES NO Low blood pressure
YES NO Asthma	YES NO Mental disorder
YES NO Back pain, surgery	YES NO Migraine headaches
YES NO Bleeding problems	YES NO Organ transplant
YES NO Blood disorder, anemia	YES NO Pain in chest, shortness of breath
YES NO Bulimia	YES NO Pacemaker
YES NO Cold sores	YES NO Persistent cough
YES NO Chemo Treatment	YES NO Radiation treatment
YES NO Circulation problems (swollen ankles, etc.)	YES NO Respiratory problems
YES NO Diabetes	YES NO Rheumatic fever
YES NO Dizziness, fainting spells	YES NO Sinus problems
YES NO Epilepsy	YES NO Stroke
YES NO Glaucoma	YES NO Tobacco use
YES NO Head or neck injury	YES NO Tuberculosis
YES NO Heart attack	YES NO Ulcers
YES NO Heart Disease	YES NO Use controlled substance
YES NO Heart Murmur	YES NO Venereal disease
YES NO Hepatitis A, B, C	YES NO Whiplash injury
YES NO High Blood Pressure	YES NO Women, are you pregnant
YES NO HIV/AIDS	YES NO Women, are you taking birth control

Do you have any disease, condition or problem not listed above we should know about? \_\_\_\_\_

Are you sensitive or allergic to any of the following:

YES NO Acrylic	YES NO Lidocaine/novacaine	YES NO Nickel
YES NO Aspirin	YES NO Ibuprofen	YES NO Penicillin
YES NO Codeine/pain pills	YES NO Iodine	YES NO Sulfa
YES NO Latex/Rubber	YES NO Mercury	Other: _____

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Hygienist Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Personal and Insurance Information

Please fill out the following information. It is very important all information stays up to date. If there are changes in this information or your health or dental histories, please let us know. Thank You.

Your Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Home Street Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

E-mail: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

May we call you at work? \_\_\_\_\_ Work Phone: \_\_\_\_\_

Social Security # \_\_\_\_\_ Marital Status: \_\_\_\_\_ Gender: **F M**

Spouse's name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_

Previous Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Street Address: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

May we ask who recommended you to us? \_\_\_\_\_

## BILLING INFORMATION

Responsible Party: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Street address: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

## INSURANCE INFORMATION

If you have insurance, please fill out the following information.

Insurance Company: \_\_\_\_\_ Subscriber # \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

Group # \_\_\_\_\_ Policy Holder's Name: \_\_\_\_\_

Policy Holder's Date of Birth: \_\_\_\_\_ Policy Holder's Social Security # \_\_\_\_\_

Employer Providing Coverage: \_\_\_\_\_