Your responses to these questions are considered strictly confidential.

MEDICAL HISTORY

Physicians's Name: _____ Phone #: _____

How would you describe your health? _____ Date of last physical _____

Have you been hospitalized or under Physicians care in the last 2 years? _____ For? _____

Please list all medications and drugs you are taking: _____

_____

Have you ever had an adverse reaction or allergies to any medication or substance? (Please circle if allergic)

Aspirin	Valium	Sulfa Drugs	Penicillin	Novocaine	Nitrous Oxide	Latex
Codeine	Iodine	Tetracycline	Erythromycin	Xylocaine	Other: _____	

Have you ever had any of the following: (Please circle all that apply)

Heart Trouble	Dizziness or Fainting	Hepatitis (type:)	HIV - AIDS - ARC
High/Low Blood Pressure	Diabetes	Cancer	Venereal Disease
Heart Attack or Stroke	Kidney or Liver Disease	Tumor or Growth	Cold Sores
Heart Murmur	Ulcers or G.I. problems	X-ray/Chemo. Therapy	Fever Blisters
Rheumatic Fever	Thyroid problems	Arthritis or Gout	Herpes
Congenital Heart problems	Asthma or Allergies	Jaw Joint Pain	Bruise easily
Heart Valve or Pacemaker	Sinus problems	Glaucoma	Frequent Thirst
Bleeding problem or Anemia	Emphysema	Epilepsy or Seizures	Freq. Urination
Blood Disease	Lung Disease	Hypoglycemia	Use Tobacco
Blood Transfusion	Tuberculosis	Drug/Alcohol Addiction	Now Pregnant
Artificial Joint	Psychiatric Care	Eating Disorder	

Do you have any condition or problem not listed above which we should know about? Please explain:

_____

_____

DENTAL HISTORY

What are your present dental concerns? _____

When did you last see a dentist? _____ When did you last have dental X-rays? _____

Have you avoided regular dental care? ☐ Yes ☐ No Why? _____

Do you feel you have active decay? ☐ Yes ☐ No Do you feel you have gum disease? ☐ Yes ☐ No

Have you ever had any periodontal (gum) treatments? ☐ Yes ☐ No

How often do you brush? _____ Floss? _____ Use other cleaning aids? _____

Are you happy with the appearance of your teeth? ☐ Yes ☐ No Would you like your teeth to be whiter? ☐ Yes ☐ No

What are your dental expectations? _____

Do you currently have problems with any of the following? (Please circle those that apply)

bleeding gums	pain when chewing	frequent tooth or fillings breaking
bad breath	jaw clicking or popping	teeth sensitive to pressure
unpleasant taste	headaches or neck pain	hot or cold tooth sensitivity
loose or chipped teeth	grinding or clenching of teeth	sweet sensitive teeth
missing teeth	sore areas in the mouth	other: _____

Previous dentist? _____ City: _____ State: _____

Would you like us to request your records from your previous dentist? ☐ Yes ☐ No Date of last dental cleaning? _____

My previous dental experience has been: ☐ positive ☐ neutral ☐ negative

EMERGENCY INFORMATION

Name of nearest relative not living with you: _____ Phone: _____

Complete Address: _____ City: _____ State: _____

Zip: _____