NAME ______________________ ______________________ ______ DATE ____________

Last First M

DENTAL HISTORY (Please Print)

1. Reason for this visit? ______________________
2. When was your last dental visit? ______________________
3. How would you describe your present dental health? ______________________

PLEASE CIRCLE YES OR NO FOR THE FOLLOWING:

4. Do you brush and floss on a routine basis? YES/NO
5. Do your gums bleed while brushing? YES/NO
6. Do your gums bleed while flossing? YES/NO
7. Do you find brushing or flossing painful? YES/NO
8. Are your teeth sensitive to hot, cold, sweet or sour foods or liquids? YES/NO
9. Does food tend to become caught between your teeth? YES/NO
10. Have you experienced any of the following problems in your jaw:
    - A. clicking? YES/NO
    - B. pain (joint, ear, side of face)? YES/NO
    - C. difficulty in opening or closing? YES/NO
    - D. difficulty in chewing? YES/NO
11. Do you have any sores or lumps in or near your mouth? YES/NO
12. Have you noticed any loosening of your teeth? YES/NO
13. Have you had any head, neck or jaw injuries? YES/NO
14. Do you have frequent headaches? YES/NO
15. Do you clench or grind your teeth? YES/NO
16. Do you bite your lips or cheeks frequently? YES/NO
17. Have you ever had:
    - A. orthodontic treatment (braces)? YES/NO
    - B. oral surgery? YES/NO
    - C. gum treatment? YES/NO
    - D. your teeth ground of bite adjusted? YES/NO
    - E. a bite plane or other appliance? YES/NO
18. Are you satisfied with the appearance of your teeth? YES/NO
19. Have you ever had an upsetting experience in the dental office? YES/NO
20. Is there anything about having dental treatment that bothers you? YES/NO

MEDICAL HISTORY

PHYSICIAN ______________________ OFFICE PHONE ______________ DATE OF LAST EXAM ______________

1. Are you under medical treatment now? YES/NO
2. Have you ever been hospitalized for any surgical operation or serious illness? YES/NO
3. Are you taking any medication(s), including non-prescription medication? YES/NO

   IF YES, PLEASE LIST ______________________

   ____
4. Do you use tobacco? YES/NO
5. Do you use alcohol, cocaine or other drugs? YES/NO
6. Are you allergic or have you had any reactions to the following:
    - A. Local anesthetic (e.g. novocaine)? YES/NO
    - B. Penicillin or other antibiotics? YES/NO
    - C. Other? YES/NO

   IF YES, PLEASE LIST ______________________

   ____

   ____
7. For women only:
    - Are you pregnant or think you may be pregnant? YES/NO
    - Are you nursing? YES/NO
    - Are you taking birth control pills? YES/NO
8. PLEASE CIRCLE IF YOU HAVE HAD ANY OF THE FOLLOWING:

Heart Trouble	Stroke	Scarlet Fever	Cancer	Hypoglycemia
High Blood Pressure	Angina	Asthma	Leukemia	S.T.D./Herpes
Low Blood Pressure	Thyroid Disease	Hay Fever/Allergies	Arthritis	Glaucoma
Heart Murmur	Diabetes	Fainting/Seizures	Swelling of feet/ankles	Ulcer
Cardiac Pacemaker	Kidney Disease	Epilepsy/Convulsions	Radiation Therapy	Artificial Joints
Chest Pain	AIDS/HIV Infection	Tuberculosis	Stomach Problems	Blood Disease
Shortness of Breath	Anemia	Emphysema	Liver Disease	Hemophilia
Heart Attack	Hepatitis/Jaundice	Respiratory Problems	Recent Weight Loss/Gain	Other

CERTIFICATION, REVIEW and UPDATES

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE, ______________________

SIGNATURE OF PATIENT OR PARENT (if minor) DATE

REVIEWED BY, ______________________ *DATE* ____________

DATE	UPDATED INFORMATION	PATIENT'S SIGNATURE	DENTIST'S SIGNATURE