



MEDICAL HISTORY & DENTAL HISTORY

Name: Mr. Mrs. Ms. _____ Date of Birth: ____/____/____

Street Address: _____
Last MI First

City: _____ State: _____ Zip Code: _____

Phone: (Primary) _____ (Work) _____ (Other) _____

General Health: Excellent Good Fair Date of last physical: ____/____/____

Physician's Name: _____ Phone: _____

Are you under current medical treatment? yes no

If yes, please explain: _____

Are you currently taking any medications or herbal supplements? yes no

If yes, please list: _____

Have you ever received medications for Osteoporosis? yes no

Do you have any allergies or adverse reaction to drugs? yes no

If yes please list: _____

Have you lost or gained more than 10 pounds in the past year? yes no

Do you desire a change in your weight? yes no

Do you use any form of tobacco? yes no Chew? yes no Smoke? yes no

What Brand? _____ How much? _____ How Long? _____

Are you interested in quitting? yes no

Women Are you: Pregnant Nursing On hormone therapy On birth control medication?

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

Acid Reflux/GERD	<input type="checkbox"/> yes <input type="checkbox"/> no	High Blood Pressure	<input type="checkbox"/> yes <input type="checkbox"/> no
Alzheimers or Dementia	<input type="checkbox"/> yes <input type="checkbox"/> no	<i>Controlled</i>	<input type="checkbox"/> yes <input type="checkbox"/> no
Artificial Joints	<input type="checkbox"/> yes <input type="checkbox"/> no	HIV or Aids	<input type="checkbox"/> yes <input type="checkbox"/> no
Bacterial Endocarditis	<input type="checkbox"/> yes <input type="checkbox"/> no	Intestinal Disease	<input type="checkbox"/> yes <input type="checkbox"/> no
Blood Disorder	<input type="checkbox"/> yes <input type="checkbox"/> no	Kidney Disease	<input type="checkbox"/> yes <input type="checkbox"/> no
Caffeine Dependency	<input type="checkbox"/> yes <input type="checkbox"/> no	Latex Sensitivity	<input type="checkbox"/> yes <input type="checkbox"/> no
Cancer/Cancer Treatment	<input type="checkbox"/> yes <input type="checkbox"/> no	Major Operations	<input type="checkbox"/> yes <input type="checkbox"/> no
Daytime Sleepiness	<input type="checkbox"/> yes <input type="checkbox"/> no	Nighttime Snoring	<input type="checkbox"/> yes <input type="checkbox"/> no
Diabetes	<input type="checkbox"/> yes <input type="checkbox"/> no	Pacemaker	<input type="checkbox"/> yes <input type="checkbox"/> no
<i>Controlled</i>	<input type="checkbox"/> yes <input type="checkbox"/> no	Prosthetic Heart Valve	<input type="checkbox"/> yes <input type="checkbox"/> no
Drug/Alcohol Dependency	<input type="checkbox"/> yes <input type="checkbox"/> no	Psychological/Psychiatric Treatment	<input type="checkbox"/> yes <input type="checkbox"/> no
Epilepsy	<input type="checkbox"/> yes <input type="checkbox"/> no	Organ Transplant	<input type="checkbox"/> yes <input type="checkbox"/> no
Fainting Spells	<input type="checkbox"/> yes <input type="checkbox"/> no	Osteoporosis/Osteopenia	<input type="checkbox"/> yes <input type="checkbox"/> no
Head Injuries	<input type="checkbox"/> yes <input type="checkbox"/> no	Respiratory Disease	<input type="checkbox"/> yes <input type="checkbox"/> no
Heart Ailment	<input type="checkbox"/> yes <input type="checkbox"/> no	Sleep Apnea	<input type="checkbox"/> yes <input type="checkbox"/> no
Hepatitis or Liver Disease	<input type="checkbox"/> yes <input type="checkbox"/> no	Stroke	<input type="checkbox"/> yes <input type="checkbox"/> no
High Cholesterol	<input type="checkbox"/> yes <input type="checkbox"/> no		

DENTAL HISTORY

How would you rate the condition of your mouth: Excellent Good Fair Poor

Previous Dentist: _____ How long were you a patient: _____

Most recent dental visit: ____/____/____ Most recent X-rays: ____/____/____

months/years

How often have you routinely seen your dentist: Every 3 months Every 4 months Every 6 months Every 12 months Not routinely

What is your immediate concern: _____

PERSONAL HISTORY (Please answer yes or no to each of the following questions)

1. Are you fearful of dental treatment? *If yes, rate on a scale of 1-10 (ten being very fearful)* _____ yes no
2. Have you had an unfavorable dental experience? yes no
3. Have you ever had trouble getting numb or reactions to local anesthetic? yes no
4. Did you ever have braces or orthodontic treatment? yes no
5. Have you had any teeth removed? yes no
6. Do you have dental implants? yes no
7. Do you wear partial dentures or dentures? yes no
8. If yes, are you satisfied with the fit? Function? Appearance? yes no

Smile Characteristics

9. *On a scale of 1-10, how would you rank the appearance of your smile?* _____ yes no
10. Have you ever whitened (bleached) your teeth? yes no
11. Are you self-conscious about your teeth? yes no
12. Have you been disappointed with the appearance of previous dental work? yes no
13. Are you interested in Botox Cosmetics for relaxation of muscles causing worry lines? yes no

Bite & Jaw Joint

14. Do you have any problems chewing bagels or other hard foods? yes no
15. Have your teeth changed in the last 5 years, become shorter, thinner or worn? yes no
16. Are your teeth crowding or developing spaces? yes no
17. Do you have more than one bite, or do you clench (squeeze) to make your teeth fit together? yes no
18. Do you have any problems with sleep in general, or wake up with an awareness of your teeth? yes no
19. Do you have problems with your jaw joint (pain, sounds, limited opening, locking, popping)? yes no
20. Do you have tension headaches or sore teeth? yes no
21. Do you wear, or have you ever worn, a bite appliance? yes no
22. Have you ever had your bite adjusted? yes no

Tooth Structure

23. Do you consider yourself cavity prone? yes no
24. Do you have any sugar habits such as pop, juice, sports drinks, candy or gum? yes no
25. Do you have a dry mouth? yes no
26. Are any teeth sensitive to hot, cold, biting or sweets? yes no
27. Have you ever had a toothache, cracked filling, or a broken, chipped or cracked tooth? yes no
28. Do you avoid brushing any part of your mouth? yes no

Gum & Bone

29. Have you ever been diagnosed or treated for periodontal (gum) disease? yes no
30. Have you ever experienced gum recession? yes no
31. Is there anyone with a history of periodontal disease in your family? yes no
32. Do your gums bleed when brushing, flossing or eating? yes no
33. Are your teeth becoming loose? yes no
34. Have you ever noticed an unpleasant taste or odor in your mouth? yes no
35. *On a scale of 1-10, how important is it for you to keep your teeth?* _____

Please share with us any other goals or ideas you may have about your oral health or appearance of your smile: _____

I consent to dental and oral surgical procedures "agreed upon." I will assume responsibility for fees associated with these procedures. To the best of my knowledge, all information I have provided is correct. I commit to informing you of any changes to my health at my next appointment.

Patient Signature: _____ Date: ____/____/____