DENTAL HISTORY

Please check any of the following problems that apply to you.

_____ Sensitivity (hot, cold, sweet)
_____ Tooth pain or discomfort when chewing
_____ Headaches, earaches, neck pain
_____ Jaw Joint Pain
_____ Teeth or fillings breaking
_____ Grinding or clenching teeth
_____ Bleeding, swollen or irritated gums
_____ Loose, tipped or shifting teeth
_____ Bad breath or bad taste in your mouth
_____ Cold or canker sores

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

_____ Dentures: Full or Partial
_____ Oral Surgery
____ Braces
_____ Periodontal (gum) treatements
_____ Root Canal Therapy

Please share the following dates:

Your last cleaning _____
Your last oral cancer screening _____
Your last complete X-rays _____

Name of Previous Dentist

_____
City: _____ Phone:_____

How can we improve on your previous dental experiences? _____
_____

If you could change your smile, you would:

_____ Make them brighter
_____ Make them straighter
_____ Repair chipped teeth
_____ Close spaces
_____ Replace black metal fillings with natural tooth-coloured fillings
_____ Replace missing teeth
_____ Replace old crowns that don't match
_____ Have a smile makeover

What is the most important thing to you about your dental visit today? _____
_____
_____

What is the most important thing to you about your future smile and dental health?

_____
_____

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

HEALTH HISTORY

Please read & check any of the following that apply to you:

___ Allergies (seasonal)
___ Anemia
___ Arthritis
___ Artificial Heart Valve
___ Artificial Joints
___ Asthma
___ Blood Disease
___ Bruise Easily
___ Cancer
___ Chemotherapy
___ Diabetes
___ Dizziness
___ Drug Addiction
___ Emphysema
___ Excessive Bleeding
___ Fainting
___ Glaucoma
___ Heart Conditions
___ Heart Lesions
___ Heart Murmur
___ Heart Surgery
___ Hepatitis A B C
___ Cannibus Use
___ High/Low Blood Pressure
___ HIV Positive
___ Jaw Joint Pain
___ Kidney Disease
___ Liver Disease/Jaundice
___ Mitral Valve Prolapse
___ Nervousness/Depression
___ Pacemaker
___ Pregnant Currently
___ Radiation (head/neck)
___ Respiratory Problems
___ Rheumatic Fever
___ Rheumatism
___ Scarlet Fever
___ Seizures
___ Sinus Problems
___ Stomach Problems
___ Stroke
___ Thyroid Disease
___ Tuberculosis
___ Ulcers
___ Venereal/STD Diseases
___ Other: _____

Do you have any of the following allergies?

___ Aspirin
___ Latex
___ metal/jewelry
___ Sulfa
___ Codeine
___ Erythromycin
___ Penicillin
___ Other:_____

Have you ever been instructed to take antibiotics prior to dental care? _____

Are you under a physicians's care? What for?

_____
_____

Are you taking any medications?

_____
_____
_____

I allow my medical doctor to be consulted if necessary.

Physician's Name: _____
Phone #: _____

The above personal, dental, and medical history is complete and accurate, and I have not knowingly withheld information. I authorize the dentist to perform diagnostic procedures and administer treatment. I will be presented options and allowed to ask questions. I understand that responsibility for payment for all procedures during treatment is mine.

_____ _____

Signed Dated

Dr. Initials _____