DENTAL HISTORY

JARROD M. LEE, DDS
HOMETOWN DENTAL
CROSSVILLE, TN

DENTAL HEALTH

Do you notice any bleeding in your gums when you brush or floss?	**Yes**	**No**	**Not Sure/ Maybe**
Do hot or cold beverages and foods cause sensitivity in your teeth?	**Yes**	**No**	**Not Sure/ Maybe**
Do you experience tooth sensitivity when consuming sweet or acidic foods/drinks?	**Yes**	**No**	**Not Sure/ Maybe**
Are any of your teeth causing you discomfort or pain?	**Yes**	**No**	**Not Sure/ Maybe**
Are there any ulcers or abnormal growths in your mouth or its surrounding area?	**Yes**	**No**	**Not Sure/ Maybe**
Have you sustained injuries to your head, neck, or jaw area? If yes, please explain.	**Yes**	**No**	**Not Sure/ Maybe**

DENTAL HISTORY

Is teeth clenching or grinding an issue for you?	**Yes**	**No**	**Not Sure/ Maybe**
Have you undergone any dental or oral surgeries, including the removal of wisdom teeth? If yes, please explain	**Yes**	**No**	**Not Sure/ Maybe**
Have you experienced extended bleeding after any dental procedures?	**Yes**	**No**	**Not Sure/ Maybe**
Have any tooth extractions been particularly troublesome for you in the past?	**Yes**	**No**	**Not Sure/ Maybe**
Have you ever received orthodontic care, such as braces?	**Yes**	**No**	**Not Sure/ Maybe**

Dentist Notes

MEDICAL HISTORY

JARROD M. LEE, DDS
HOMETOWN DENTAL
CROSSVILLE, TN

Have you ever been hospitalized for any illnesses or operations? If yes, please explain.

Yes **No** **Not Sure/ Maybe**

Do you have or have you ever had any of the following? Please circle

Angina
Arthritis
Cancer
Chest Pain
Diabetes
Drug/ Alcohol/ Cannabis Use or Dependency
Heart Murmur
Heart Attack
Kidney Disease
Lung Disease
Mitral Valve Prolapse
Medications (Fosamax, Actonel)
Osteoporosis
Pacemaker
Rheumatic Fever
Stomach Ulcers
Thyroid Disease
Transient Ischemic Attack
Tuberculosis
Stroke
Steroid Therapy
Seizures (Epilepsy)

Are there any conditions or diseases not listed above that you have or have had? If yes, please explain.

Yes **No** **Not Sure/ Maybe**

Are there any diseases or medical problems that run in your **family** (e.g. diabetes, cancer or heart disease)?

Yes **No** **Not Sure/ Maybe**

Do you smoke or chew tobacco products? **Yes** **No** **Not Sure/ Maybe**

Are you nervous during dental treatment? **Yes** **No** **Not Sure/ Maybe**

Are you breastfeeding or pregnant? If pregnant, what is the expected delivery date?

Yes **No** **Not Sure/ Maybe**

Do you identify as a patient with a disability? If yes, please explain. **Yes** **No** **Not Sure/ Maybe**

To the best of my knowledge, the above information is correct:

Patient/Parent/Guardian Signature: Date:

Dentist Signature: Date:

Dentist Notes

MEDICAL HISTORY

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HOMETOWN DENTAL
CROSSVILLE, TN

Are you currently being treated for any medical conditions or have been treated within the past year? If Yes please explain:
(Please Circle) **Yes** **No** **Not Sure/ Maybe**

When was your last medical check up?:

Have there been any health changes for you in the past year? If Yes. Please explain.

Yes **No** **Not Sure/ Maybe**

Are you taking any medications, non-prescription drugs or herbal supplements of any kind? If yes, please list them.

Yes **No** **Not Sure/ Maybe**

Do you have any allergies? If yes, please list them below: **Yes** **No** **Not Sure/ Maybe**

a) medications

b) latex/rubber products

c) other

Have you ever had a peculiar or adverse reaction to any medicines or injections? If yes, please explain.

Yes **No** **Not Sure/ Maybe**

Do you have or have you ever had asthma? **Yes** **No** **Not Sure/ Maybe**

Do you have or have you ever had any heart or blood pressure problems? **Yes** **No** **Not Sure/ Maybe**

Do you have or have you ever had a replacement or repair of a heart valve, an infection of the heart (i.e. infective endocarditis), a heart condition from birth (i.e. congenital heart disease) or a heart transplant?

Yes **No** **Not Sure/ Maybe**

Do you have a prosthetic or artificial joint? **Yes** **No** **Not Sure/ Maybe**

Do you have any conditions or therapies that could affect your immune system (e.g. leukemia, AIDS, HIV infection, radiotherapy, chemotherapy)? **Yes** **No** **Not Sure/ Maybe**

Have you ever had hepatitis, jaundice or liver disease? **Yes** **No** **Not Sure/ Maybe**

Do you have a bleeding problem or bleeding disorder? **Yes** **No** **Not Sure/ Maybe**

PATIENT INFORMATION

JARROD M. LEE, DDS
HOMETOWN DENTAL
CROSSVILLE, TN

PERSONAL INFORMATION

Full Name :

Home Address :

Date of Birth : / /

Gender :

Pronouns:

Day-time Phone:

Email :

Occupation:

Business Address:

Work Phone:

EMERGENCY DETAILS

Name:

Relationship:

Day-time Phone:

Name:

Relationship:

Day-time Phone:

Family Doctor:

Phone:

Address:

Specialist:

Phone:

Address:

INSURANCE

Primary Insurance

Holder:

Insurance Co:

Group #:

Member #:

Phone:

Secondary Insurance

Holder:

Insurance Co:

Group #:

Member #:

Phone:

How did you hear about our office? (Please Circle)

Online Search Social Media Reviews Advertisment Friend/ Family Member Other: