DENTAL HISTORY



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

Not Sure/ Maybe

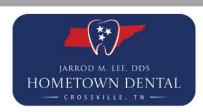
Yes



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

Do you have or h	ave you ever had any of the	following? Please	circle		
	Heart Murmur Heart Attack Kidney Disease Lung Disease Mitral Valve Prolapse abis Use or Dependency nditions or diseases not liste		Medications (Fosamax, Osteoporosis Pacemaker Rheumatic Fever Stomach Ulcers		Thyroid Disease Transient Ischemic Attack Tuberculosis Stroke Steroid Therapy Seizures (Epilepsy)
Tes Two	Not Sure, maybe				
Are there any dis	seases or medical problems	that run in your f e	amily (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 breastfee Yes No	eding or pregnant? If pregna Not Sure/ Maybe	ant, what is the exp	pected delivery date?		
Do you identify a	s a patient with a disability?	If yes, please expl	ain. Yes N	No Not Sure	e/ Maybe
To the best of my	knowledge, the above infor	mation is correct:			
	zknowledge, the above infor Parent/Guardian Signature:	mation is correct:		Date:	
		rmation is correct:		Date:	

MEDICAL HISTORY



Are you	currently	being tre	ated for a	any medical condi	ions or l	ave been tre	ated within the p	ast year? If Yes please explain:
(Please C	Circle)	Yes	No	Not Sure/ Maybe				
When wa	as your la	ast medica	l check u	p?:				
Uavo tho	no boon	any boolth	ahangas	for you in the nee	t woon? If	Voc. Dlanca c	valain	
				for you in the pas	ı year: II	res. Flease e	хріат.	
Yes	No	Not Sure	e/ Maybe					
Are you t	taking ar	185 170-17 170-181		n-prescription dru	gs or her	bal suppleme	ents of any kind?	If yes, please list them.
Yes	No	Not Sure	e/ Maybe					
The U.S.		450 VVV 7540						
85%	8.5	allergies?	lf yes, ple	ase list them belo	w: Yes	No	Not Sure/ May	oe .
a) medic		540 N 100						
b) latex/r	1.00	roducts						
c) other								
Have you	ı ever ha	d a neculi:	ar or adv	erse reaction to ar	v medici	nes or inject	ions? If ves inleas	se explain
Yes	No		e/ Maybe	orso reaction to ar	ij mediei	nes or inject	101101 11 y 00, produ	o capitalli
103	110	NOI DUI	, maybe					
	and the second of the second o							
Do you h	ave or h	ave you ev	er had as	sthma? Yes	No	Not Sure/ N	Maybe	
Do vou h	ave or h	ave vou ev	er had ar	ny heart or blood p	ressure	problems?	Yes No	Not Sure/ Maybe
		7		,				
Do you h	ave or h	ave you ev	er had a	replacement or re	pair of a	heart valve, a	an infection of th	e heart (i.e. infective
endocard	litis), a h	eart cond	ition fron	n birth (i.e. conger	ital hear	t disease) or	a heart transplar	nt?
Yes	No	Not Sure	e/ Maybe					
Do you h	0.00 0 0.00	oethotia or	ontificio	Ligint? Vos	No	Not Suro/ N	Anybo	
Do you n	ave a pr	osthetic or	aruncia	l joint? Yes	No	Not Sure/ N	viay De	
Do you h	ave any	conditions	or thera	pies that could aff	ect your	immune syst	em (e.g. leukemia	a, AIDS, HIV infection,
radiothe	rapy, che	motherap	y)? Yes	No N	ot Sure/ N	laybe	tti can	
	rudir					VIV.		
Have you	ı ever ha	d hepatitis	, jaundic	e or liver disease?	Yes	No	Not Sure/ Maybe	
Do you b	avo a ble	oding pro	hlom or l	alooding disarder?	Yes	No	Not Sure/ Maybe	

PATIENT INFORMATION



PERSONAL INFORMATION Full Name: Home Address: **Pronouns:** Gender: Date of Birth: Email: Day-time Phone: **Business Address:** Occupation: Work Phone: **EMERGENCY DETAILS** Name: Name: Relationship: Relationship: Day-time Phone: Day-time Phone: Family Doctor: Specialist: Phone: Phone: Address: Address: **INSURANCE Primary Insurance Secondary Insurance** Holder: Holder: Insurance Co: **Insurance Co:** Group #: Group #: Member #: Member #:

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

Phone:

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

Phone: