



PATIENT NAME \_\_\_\_\_

DATE \_\_\_\_\_

Primary reason for this dental appointment:  Examination  Emergency  Consultation

**Dental**

Please

Circle

- Do you have a specific dental problem? Describe \_\_\_\_\_ Yes No
Do you have dental examinations on a routine basis? Last visit \_\_\_\_\_ Yes No
Do you think you have active decay or gum disease? \_\_\_\_\_ Yes No
Do you brush and floss on a routine basis? Discuss \_\_\_\_\_ Yes No
Do your gums ever bleed? Discuss \_\_\_\_\_ Yes No
Do you like your smile? Why? \_\_\_\_\_ Yes No
Does food catch between your teeth? Any loose teeth? \_\_\_\_\_ Yes No
Do you want to keep your remaining teeth? \_\_\_\_\_ Yes No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? \_\_\_\_\_ Yes No
Have your past experiences in a dental office always been positive? \_\_\_\_\_ Yes No
Do you smoke or chew? Any sores or growths in your mouth? Discuss \_\_\_\_\_ Yes No
Name of current dentist (optional): \_\_\_\_\_
Date of last full mouth x-rays (16 small films or panoramic): \_\_\_\_\_

**Medical**

- Are you under a physician's care now? \_\_\_\_\_ Yes No
Why? \_\_\_\_\_ Who? \_\_\_\_\_ Phone \_\_\_\_\_
Have you ever been hospitalized or had a major operation? Discuss \_\_\_\_\_ Yes No
Have you ever had a serious injury to your head or neck? Discuss \_\_\_\_\_ Yes No
Are you taking any medications, pills or drugs? What? \_\_\_\_\_ Ever taken fen-phen?\* \_\_\_\_\_ Yes No
Are you on a special diet? Discuss \_\_\_\_\_ Yes No
Are you allergic to any medications or substances? Please check box below \_\_\_\_\_ Yes No
[ ] Aspirin [ ] Penicillin [ ] Codeine [ ] Acrylic [ ] Metal [ ] Latex Rubber [ ] Other \_\_\_\_\_
Women (Please check) [ ] Pregnant/trying to get pregnant [ ] Nursing [ ] Taking oral contraceptives - Discuss \_\_\_\_\_ Yes No

Do you now have or have you ever had any of the following? Please check appropriate boxes.
\*If yes to any of the starred conditions, please call prior to your appointment...premedication may be required.

Table with 4 columns of conditions and Yes/No checkboxes. Conditions include Heart Trouble/Disease, Bruise Easily, Emphysema, Yellow Jaundice, etc.

Have you ever had any other serious illness not checked above? Discuss \_\_\_\_\_ Yes No
Do you wish to talk to the dentist privately about any problem? \_\_\_\_\_ Yes No
To the best of my knowledge all the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

X \_\_\_\_\_ Date \_\_\_\_\_
PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor \_\_\_\_\_ Date \_\_\_\_\_ BP \_\_\_\_\_

History Review and Significant Findings \_\_\_\_\_

**Medical**

I have read my MEDICAL HISTORY dated \_\_\_\_\_ and confirm that it adequately states past and present conditions.
DATE EXCEPTIONS PATIENT'S SIGNATURE BP REVIEWED BY
\_\_\_\_\_ NONE [ ] \_\_\_\_\_ \_\_\_\_\_ Dr. \_\_\_\_\_
\_\_\_\_\_ NONE [ ] \_\_\_\_\_ \_\_\_\_\_ Dr. \_\_\_\_\_
\_\_\_\_\_ NONE [ ] \_\_\_\_\_ \_\_\_\_\_ Dr. \_\_\_\_\_
\_\_\_\_\_ NONE [ ] \_\_\_\_\_ \_\_\_\_\_ Dr. \_\_\_\_\_
\_\_\_\_\_ NONE [ ] \_\_\_\_\_ \_\_\_\_\_ Dr. \_\_\_\_\_

**DENTAL AND MEDICAL HISTORIES - UPDATES**