

DATE: _____

 PATIENT NAME: _____ BIRTH DATE: _____ AGE: _____
LAST FIRST
DENTAL HISTORY

- Are there other conditions of which we should be aware? YES _____ NO _____ If yes, please specify: _____
- Why are you here today? Check-Up _____ Cleaning _____ Other _____
 Toothache _____ Chief Complaint _____
- When did you last visit a dentist? _____
- What treatment was performed? _____
- Was the treatment completed? _____
- Did you have a cleaning? _____
- When were dental x-rays taken? _____
- Have you ever had prolonged bleeding after an extraction? YES _____ NO _____ If yes, please specify: _____
- Have you had any problems with past dental treatment? YES _____ NO _____ If yes, please specify: _____
- Do you have symptoms near your ears associated with movement of your lower jaw such as clicking, popping, pain or locking open? YES _____ NO _____ If yes, please specify: _____
- Have you ever been diagnosed or treated for TMD (Temporomandibular Joint Dysfunction sometimes called TMJ)? YES _____ NO _____ If yes, please specify: _____
- Do your gums bleed easily? YES _____ NO _____
- Do you feel you have bad breath? YES _____ NO _____
- Are your teeth sensitive to hot or cold? YES _____ NO _____
- Would you like your teeth whiter? YES _____ NO _____
- Are there any cosmetic changes you would like to have done on your teeth? YES _____ If yes, please specify: _____

MEDICAL HISTORY

- Who is your primary doctor? _____
Dr. Ph # () _____
- Are you allergic to penicillin, codeine, local anesthetics, tranquilizers, latex, or any other drugs or medicine? _____
- Are you taking any medication at this time, including birth control? YES _____ NO _____ If yes, please specify: _____
- (Woman) Are you pregnant at this time? YES _____ NO _____ If yes, please specify how many months: _____
- Are there any other health problems of which we should be advised? Please specify: _____
- Do you have, or have you had, any of the following?

Please check "YES" or "NO"		Doctor Comments	Please check "YES" or "NO"		Doctor Comments
ARTIFICIAL Heart Valve	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	HEART PROBLEMS	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
AIDS/HIV+	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	HEPATITIS	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
ANEMIA	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	HIGH BL. PRESSURE	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
ANGINA	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	JAUNDICE	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
ARTHRITIS	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	JOINT PROSTHESIS	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
ASTHMA	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	KIDNEY DISEASE	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
BLEEDING PROBLEMS	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	LIVER PROBLEMS	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
CANCER	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	LOW BL. PRESSURE	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
CHEMO/RAD THERAPY	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	LUNG DISEASE	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
COSMETIC SURGERY	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	PACEMAKER	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
DIABETES	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	PSYCHIATRIC CARE	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
DIZZY SPELLS	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	RHEUMATIC FEVER	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
DRUG ADDICTION	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	SINUS TROUBLE	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
EMPHYSEMA	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	SMOKING TOBACCO	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
EPILEPSY	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	STROKE	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
FAINTING	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	THYROID PROBLEMS	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
GLAUCOMA	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	TMD OR TMJ	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
HEART ATTACK	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	TUBERCULOSIS	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
HEART SURGERY	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	VENEREAL DISEASE	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____
HEART MURMUR	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____	FEN-PHEN	YES <input type="checkbox"/> NO <input type="checkbox"/>	_____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I further certify that I consent to the performing of x-rays and oral examination.

 Patient's signature _____ Date _____
(or Parent if patient is a minor)

Doctor Signature _____

RECALL REVIEW:

- | | | |
|------------------------------|--------------------------|------------|
| 1. Patient's signature _____ | Doctor's Signature _____ | Date _____ |
| 2. Patient's signature _____ | Doctor's Signature _____ | Date _____ |
| 3. Patient's signature _____ | Doctor's Signature _____ | Date _____ |