

DENTAL HISTORY

Please check any of the following problems that apply to you.				If you could whiten your teeth for a cost anyone could afford, would you do it?	<input type="checkbox"/>
-Sensitivity (hot, cold, sweet) Where? UR LR UL LL	<input type="checkbox"/>			Do you smoke or use chewing tobacco? How much? For how long?	<input type="checkbox"/>
-Headaches, earaches, neck pain	<input type="checkbox"/>			If I could change my smile, I would:	<input type="checkbox"/>
-Jaw joint pain	<input type="checkbox"/>			-Make them whiter	<input type="checkbox"/>
-Teeth or fillings breaking	<input type="checkbox"/>			-Make them straighter	<input type="checkbox"/>
-Grinding or clenching teeth	<input type="checkbox"/>			-Close spaces	<input type="checkbox"/>
-Bleeding, swollen or irritated gums	<input type="checkbox"/>			-Replace black metal fillings with tooth colored restorations	<input type="checkbox"/>
-Loose, tipped or shifting teeth	<input type="checkbox"/>			-Repair chipped teeth	<input type="checkbox"/>
-Bad breath	<input type="checkbox"/>			-Replace missing teeth	<input type="checkbox"/>
Do you have or have you had any of the following?				-Replace old crowns that don't match	<input type="checkbox"/>
-Dentures	<input type="checkbox"/>			-Have a smile makeover	<input type="checkbox"/>
-Partial dentures	<input type="checkbox"/>			On a scale of 1 – 10, with 10 being the highest rating:	
-Braces	<input type="checkbox"/>			-How important is your dental health to you?	
-Periodontal (gum) treatments	<input type="checkbox"/>			1 2 3 4 5 6 7 8 9 10	
Please share the following dates:				-Where would you rate your current dental health?	
-Your last cleaning	_ / _			1 2 3 4 5 6 7 8 9 10	
-Your last oral cancer screening	_ / _			-Where do you want your dental health to be?	
-Your last complete X-Rays	_ / _			1 2 3 4 5 6 7 8 9 10	
Name of Previous Dentist				Why did you leave your previous dentist?	
City _____ State _____					
Phone Number _____					
What is the most important thing to you about your future smile and dental health?				What is the most important thing to you about your dental visit today?	

MEDICAL HISTORY

Please check any of the following that apply to you:			
<input type="checkbox"/> AIDS	<input type="checkbox"/> Drug Addiction	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Allergies (Seasonal)	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Rheumatism
<input type="checkbox"/> Anemia	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Jaw Joint Pain	<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Fainting	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Seizures
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Stomach Problems
<input type="checkbox"/> Artificial Joints	<input type="checkbox"/> Heart Conditions	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Stroke
<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart Lesions (Congenital)	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Nervousness/Depression	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Bruise Easily	<input type="checkbox"/> Heart Surgery	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Phen Fen (1 month +)	<input type="checkbox"/> Venereal Diseases
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Pregnant Currently	<input type="checkbox"/> Other
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Radiation (head/neck)	
<input type="checkbox"/> Dizziness	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Respiratory Problems	
Do you have any of the following drug allergies?		Are you under a physician's care? What for?	
<input type="checkbox"/> Aspirin	<input type="checkbox"/> Codeine	_____	
<input type="checkbox"/> Darvon	<input type="checkbox"/> Erythromycin	Are you taking any medications? What?	
<input type="checkbox"/> Nitrous Oxide	<input type="checkbox"/> Valium	_____	
<input type="checkbox"/> Percodan	<input type="checkbox"/> Penicillin	Family Physician	Phone Number
<input type="checkbox"/> Local Anesthetic	<input type="checkbox"/> Sulfa	_____	_____
<input type="checkbox"/> Tetracycline	<input type="checkbox"/> Other	_____	_____
Patient Signature (Parent of Child)	Date	Dentist Signature	