Name of Patient:___________________________________ **Date:**____________________

Dental History____

Reason for Today's Visit_______________________ Date of Last Dental Care_____________

Former Dentist_____________________________ Date of Last Dental X-rays____________

Circle, If you have or have had problems with any of the following:

Bad Breath / Grinding Teeth / Sensitivity to hot or cold / Bleeding Gums / Loose Teeth or Broken Fillings / Sensitivity to Sweets / Clicking or Popping Jaw / Periodontal Treatment / Sensitivity when Biting /Food Collecting between the Teeth / Sores or Growths in Mouth/ Others:

____

How Often do you floss? _______________ How Often do you Brush? _______________________

Medical History:____

Physician's Name: ____________________________ Date of Last Visit _______________________

Have you had any serious illnesses or operations? (Yes) or (No) If yes, describe: ___________________

(Women) Are you pregnant? (Yes) or (No) Nursing? (Yes) or (No) Taking birth control? (Yes) or (No)

Check If you have or have had problems with any of the following:

Anemia	Congenital Heart Lesions	Hepatitis	Scarlet Fever
Arthritis, Rheumatism	Cortisone Treatments	High Blood Pressure	Shortness of Breath
Artificial Heart Valves	Cough, Persistent	HIV/AIDS	Skin Rash
Artificial Joints, Pins, Etc	Cough up Blood	Jaw Pain	Stroke
Asthma	Diabetes	Kidney Disease	Thyroid Problems
Back Problems	Epilepsy	Liver Disease	Tobacco Habit
Bleeding Abnormally	Fainting	Mitral valve prolapse	Tonsillitis
Blood Disease	Glaucoma	Pacemaker	Tuberculosis
Cancer	Headaches	Radiation Treatment	Others:
Chemical Dependency	Heart Murmur	Respiratory Disease	
Circulatory Disease	Heart Problems	Rheumatic Fever	
Chemotherapy	Hemophilia	Ulcers	

List of Medications you are currently taking: ____

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Allergies (Circle any that apply) If none Skip :

Aspirin / Local Anesthetic / Iodine / Barbiturates / Penicillin / Latex / Codeine / Sulfa / Others:

____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, Or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative: ___________________________________