Confidential

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Family Dentistry

Patient Information

Patient Name: _____ Date: _____
Last First MI

Medical History

1. Are you in good health? ☐ Yes ☐ No

2. Have there been any changes in your general health within the past year? ☐ Yes ☐ No
If yes, please explain: _____

3. Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
If yes, please explain: _____

4. Are you now under the care of a physician? ☐ Yes ☐ No
If yes, please explain: _____

5. Name of Physician: _____ Phone:_____

6. Are you taking any medication(s) including non-prescription medication? ☐ Yes ☐ No
If yes, please list. _____

Do you have or have you ever had any of the following? Please check those that apply:

- ☐ AIDS or HIV
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy
  Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Anesthetic Allergy
- ☐ Latex Allergy
- ☐ Acrylic Allergy
- ☐ Metal Allergy

- Do you have any health problems that need further clarification? ☐ Yes ☐ No
If yes, please explain: _____

Dental History

Date of Last Dental Visit: _____ Reason for today's visit:_____

How often do you brush your teeth? _____ What texture brush do you use? ☐ Soft ☐ Medium ☐ Hard

Do your gums bleed while brushing?	☐ Yes ☐ No	Do you have any mouth sores or lumps?	☐ Yes ☐ No
Do your gums bleed while flossing?	☐ Yes ☐ No	Have you had any head, neck or jaw injuries?	☐ Yes ☐ No
Are your teeth sensitive to hot or cold foods/liquids?	☐ Yes ☐ No	Do you clench or grind your teeth while awake or asleep?	☐ Yes ☐ No
Have you noticed any loosening of your teeth?	☐ Yes ☐ No	Do you bite your lips or cheeks frequently?	☐ Yes ☐ No
Does food tend to get caught between your teeth?	☐ Yes ☐ No	Are you satisfied with the appearance of your teeth?	☐ Yes ☐ No
Have you ever had any of the following dental treatments?		Have you experienced any of the following problems in your jaw?	
a. Orthodontics (braces)?	☐ Yes ☐ No	a. Clicking?	☐ Yes ☐ No
b. Oral surgery?	☐ Yes ☐ No	b. Pain (joint, ear, side of face)?	☐ Yes ☐ No
c. Gum treatment?	☐ Yes ☐ No	c. Difficulty in opening or closing?	☐ Yes ☐ No
d. Your teeth ground or bite adjusted?	☐ Yes ☐ No	d. Difficulty in chewing?	☐ Yes ☐ No
e. Bite plane or other appliance?	☐ Yes ☐ No		

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian