Patient Name___________________________________ **Date of Birth** ____

Dental History

Check ☑ if you have had problems with any of the following:

☐ Bad Breath ☐ Grinding Teeth ☐ Sensitivity to hot

☐ Bleeding gums ☐ Loose Teeth or broken fillings ☐ Sensitivity to sweets

☐ Clicking or popping jaw ☐ Periodontal treatment ☐ Sensitivity when biting

☐ Sensitivity to cold ☐ Sores or growths in your mouth ☐ Food collection between teeth

Medical History

Physician's Name______________________ **Telephone Number**______________ **Date of Last Visit**________________

Have you had any serious illnesses or operations? ____________________ **If yes, describe**

____

Check ☑ if you have or have had any of the following:

☐ High Blood Pressure ☐ Heart Disease ☐ Heart Attack ☐ Heart Murmur

☐ Low Blood Pressure ☐ Stroke ☐ Rheumatic fever ☐ Angina

☐ Cardiac Pacemaker ☐ Anemia ☐ Fainting/Seizures ☐ Tuberculosis

☐ Epilepsy/Convulsions ☐ Asthma ☐ Emphysema ☐ Respiratory problems

☐ Cancer ☐ Radiation therapy ☐ Chemotherapy ☐ Leukemia

☐ Diabetes ☐ Liver Disease ☐ Kidney Disease ☐ Thyroid Disease

☐ Arthritis ☐ Joint Replacement ☐ Hepatitis ☐ Stomach trouble/Ulcers

☐ Swollen Ankles ☐ Recent Weight Loss ☐ Frequently Tired ☐ AIDS/ HIV infection

☐ Hay Fever/Allergies ☐ Sexually Transmitted Disease ☐ Other ☐ **None**

Comments____

Medications____ ☐ **None**

Allergies ☐ Latex ☐ Penicillin ☐ Sulfa Drugs ☐ Dental Anesthetics ☐ Aspirin ☐ Other ☐ **None**

____

Women

Are you pregnant? ☐ Yes ☐ No **Nursing?** ☐ Yes ☐ No **Taking Birth Control?** ☐ Yes ☐ No

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered and I understand that providing incorrect information can be dangerous to my health.

____ _________________________

Patient, Parent, or Guardian's Signature Date