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