DENTAL HISTORY

Patient Name: ____

DENTAL HISTORY

1. Is this your first visit to a dentist? .... YES NO
2. Do you have dental pain, bleeding gums or sensitive teeth? .... YES NO
3. Have you ever had an injury to your face or jaw or do you have jaw pain? .... YES NO
4. Have you ever had any problems associated with dental treatment.................. YES NO
5. Do you brush and floss your teeth and mouth daily? .... YES NO
6. Do you currently, or have you ever used tobacco products? .... YES NO
   If yes, explain____
7. Do you use fluoride tablets or rinses? .... YES NO
8. What type of dental treatment do you feel you need? ____________________________

MEDICAL HISTORY

The following information is necessary for you to receive dental treatment and will be completely confidential. Dental treatment will not be refused because of existing medical conditions.

1. Are you receiving any type of medical treatment or have you been hospitalized? .... YES NO
2. Have you had a recent illness or surgery? .... YES NO
3. Are you taking any prescription, non-prescription or herbal medications.............................. YES NO
   If yes, list them____
   ____
4. Are you allergic to any medications or to latex? .... YES NO
   If yes, list them ____
5. Have you ever had excessive bleeding requiring medical treatment? .... YES NO
6. If female, are you pregnant? YES NO. If yes, when are you due? ____________________________
7. List your medical provider's name and phone number ____________________________

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8. Indicatewhich of the following you have had or have at present. Please circle.

High Blood Pressure	Prosthetic Heart Valve	Allergies or Hives	Osteoporosis
Heart Disease/Surgery	Congenital Heart Defect	Tuberculosis	Arthritis
Heart Murmur	Epilepsy/Seizures	Psychiatric Treatment	Stroke
Artificial Joints	Headaches	AIDS or HIV Positive	Cancer/Chemotherapy
Kidney Disease	Sinus Problems	Hepatitis/Liver Disease	ED Drug Therapy
Sexually Transmitted Disease	Nervousness	Organ Transplant	Steroid Medications
Diabetes	Fainting/Dizziness	Blood Transfusions	Sickle Cell Disease
Chest Pain/Angina	Bisphosphonate Drugs	Alcohol/Drug Dependency	Glaucoma
Endocarditis	Ulcers	Asthma	**None of the Above**

9. Do you have any disease, condition or problem not listed above? YES NO Explain:____________________

I certify that the information given is complete and correct. Any necessary treatment is hereby authorized.

Patient or Legal Guardian Signature ____________________ **Date** ____________________

Precautions for Dental Treatment: