DENTAL HEALTH HISTORY (Confidential)

Patient Name _____ (Last / First / Initial)

Today's Date _____

Birthdate _____

Address _____

City _____ State _____ Zip _____

Phone _____ Work _____

SS# _____

DENTAL HISTORY

Reason for Today's Visit _____

Former Dentist _____ Address _____

Date of last dental care _____ Date of last dental X-rays _____

Check (✔) if you have had problems with any of the following

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to Sweets
- ☐ Sensitivity to biting
- ☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Phone _____ Date of Last Visit _____

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

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

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

Check (✔) if you have or have had any of the following:

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Aritificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- Describe _____
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

MEDICATIONS

List Medications you are currently taking:

_____

_____

_____

Pharmacy Name _____

Phone _____

ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates (Sleeping pills)
- ☐ Codeine
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Other _____

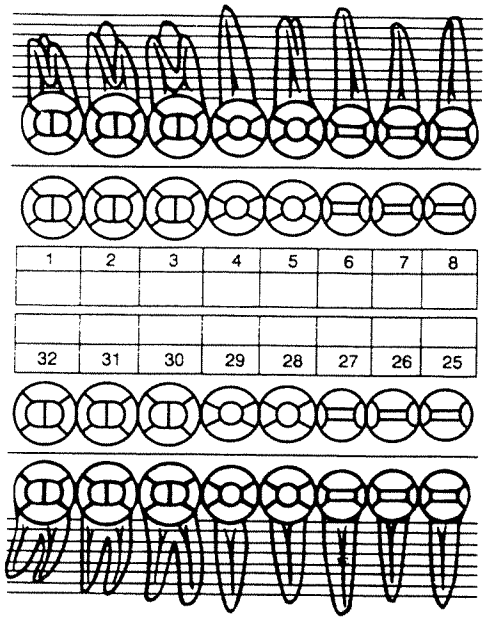
SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ Signature _____ Date _____ Signature _____

Date _____ Signature _____ Date _____ Signature _____

RIGHT



1	2	3	4	5	6	7	8
32	31	30	29	28	27	26	25

1. Existing Illnesses

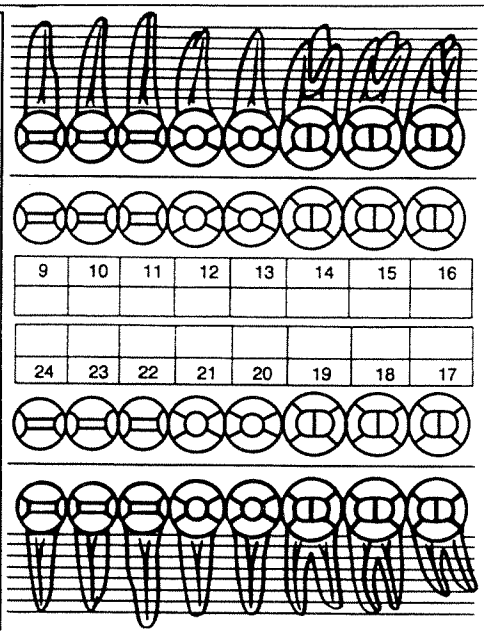
2. Current Drugs Used

3. Allergies

4. Chief Dental Complaint

5. Oral Habits

6. Oral Hygiene



9	10	11	12	13	14	15	16
24	23	22	21	20	19	18	17

LEFT

DATE COMPLETED	TOOTH	SURFACE	TREATMENT	FEE	DATE COMPLETED	TOOTH	SURFACE	TREATMENT	FEE

PATIENT'S NAME

DENTAL TREATMENT

❑ **MEDICAL ALERT**

Date	Tooth	Service	Charge	Paid	Balance

Date	Tooth	Service	Charge	Paid	Balance