

Welcome to Our Office

As a health-centered dental practice, we are concerned with your total well-being. We appreciate your thoroughness in your medical health and dental health information.

Patient Name: _____ Preferred Name: _____

What are your hobbies or special interests? (For example: Sports, travel, education).

Health History

Do you have or have you ever had any of the following:

	YES	NO		YES	NO
Hypoglycemia, Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack, Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever, Asthma, Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Anemia, Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Low/High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory Problems	<input type="checkbox"/>	<input type="checkbox"/>	Fainting, Blackouts	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis, Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Nervous Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Lung Problems, Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Headaches, Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy, Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>
Blood Transfusions	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma, Eye Problems	<input type="checkbox"/>	<input type="checkbox"/>
Facial or Head Injuries	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers, Digestive Problems	<input type="checkbox"/>	<input type="checkbox"/>
Radiation Treatments	<input type="checkbox"/>	<input type="checkbox"/>	HIV Pos. or AIDS/ARC	<input type="checkbox"/>	<input type="checkbox"/>
Malignancies, Cancer	<input type="checkbox"/>	<input type="checkbox"/>			
Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>	Are You Pregnant Now	<input type="checkbox"/>	<input type="checkbox"/>
Recent Weight Gain/Loss	<input type="checkbox"/>	<input type="checkbox"/>	Due Date: _____		
History of Drug or Alcohol Abuse ...	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco Use	<input type="checkbox"/>	<input type="checkbox"/>
Joint Replacement	<input type="checkbox"/>	<input type="checkbox"/>	Chewing: _____ Smoking: _____		
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	How much per day? _____		
Replacement of Heart Valves	<input type="checkbox"/>	<input type="checkbox"/>	Other _____		
Stroke	<input type="checkbox"/>	<input type="checkbox"/>			

Have you seen your physician or been hospitalized in the last two years? If yes, please explain

Name of Physician: _____

Have you had unfavorable reactions to any of the following? (Please Circle) Aspirin Codeine

Anesthetics Novocaine Sedatives Penicillin (Antibiotics) Other Drugs _____

Please list any drugs/medication/over the counter/herbal supplements currently being taken:

Medicine: _____ Condition: _____ Medicine: _____ Condition: _____

Medicine: _____ Condition: _____ Medicine: _____ Condition: _____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have a change in my health, or if my medicines change, I will inform the dentist at the next appointment without fail. I consent to whatever dental procedures and anesthetics are necessary for treatment.

Date _____ Signature of patient, parent, or guardian _____

Date _____ Initial _____ / Date _____ Initial _____ / Date _____ Initial _____

Dental Health Information

Thank you for providing us with important information that will help us serve you better.

Does dental treatment make you nervous?	YES	NO	Do you think your dental health affects your overall health?	YES	NO
Is the brightness of your teeth important to you?	<input type="checkbox"/>	<input type="checkbox"/>	Do you think it is important to have your teeth cleaned at least every six months?	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink coffee or tea?	<input type="checkbox"/>	<input type="checkbox"/>	Do you prefer to save your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you take a flouride supplement?	<input type="checkbox"/>	<input type="checkbox"/>			

Have you noticed any of the following?

Teeth tender to chew on	YES	NO	Sensitivity to sweets	YES	NO
Discomfort in face, head, neck	<input type="checkbox"/>	<input type="checkbox"/>	Recurring sore in or around mouth ...	<input type="checkbox"/>	<input type="checkbox"/>
Food caught between teeth	<input type="checkbox"/>	<input type="checkbox"/>	Jaw clicking or popping	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding or sore gums	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to hot/cold	<input type="checkbox"/>	<input type="checkbox"/>
Bad breath	<input type="checkbox"/>	<input type="checkbox"/>	Swelling, lumps in mouth	<input type="checkbox"/>	<input type="checkbox"/>
Grinding of teeth	<input type="checkbox"/>	<input type="checkbox"/>	Snoring	<input type="checkbox"/>	<input type="checkbox"/>

Have you had any upsetting experiences in the dental office? _____

If yes, please explain: _____

If I could change my smile, I would want my teeth:

Whiter	YES	NO
Straighter	<input type="checkbox"/>	<input type="checkbox"/>
Close space	<input type="checkbox"/>	<input type="checkbox"/>
Replace mercury fillings with tooth colored restorations	<input type="checkbox"/>	<input type="checkbox"/>
Repair chipped teeth	<input type="checkbox"/>	<input type="checkbox"/>
Less gum showing	<input type="checkbox"/>	<input type="checkbox"/>
Replace old crowns or caps that don't match	<input type="checkbox"/>	<input type="checkbox"/>

On a scale of 1 to 10 with 10 being the highest rating:

How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?
1 2 3 4 5 6 7 8 9 10

Where would you like your dental health to be?
1 2 3 4 5 6 7 8 9 10

Circle One

When was the last time you had an oral cancer exam? Date of last cleaning:

If there were a way to whiten your teeth for a very reasonable investment, would you be interested?

What is the most important thing to you about your future smile and dental health?

What is the most important thing to you about your dental visit today?
