Welcome to Our Office

As a health-centered dental practice, we are concerned with your local 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	❒	❒	Heart Murmur	❒	❒
Heart Attack, Heart Trouble	❒	❒	Rheumatic Fever	❒	❒
Hay Fever, Asthma, Allergies	❒	❒	Anemia, Blood Disorder	❒	❒
Low/High Blood Pressure	❒	❒	Excessive Bleeding	❒	❒
Circulatory Problems	❒	❒	Fainting, Blackouts	❒	❒
Hepatitis, Jaundice	❒	❒	Nervous Disorders	❒	❒
Lung Problems, Tuberculosis	❒	❒	Headaches, Migraines	❒	❒
Epilepsy, Seizures	❒	❒	Kidney Problems	❒	❒
Blood Transfusions	❒	❒	Glaucoma, Eye Problems	❒	❒
Facial or Head Injuries	❒	❒	Ulcers, Digestive Problems	❒	❒
Radiation Treatments	❒	❒	HIV Pos. or AIDS/ARC	❒	❒
Malignancies, Cancer	❒	❒	Are you pregnant now?	❒	❒
Sinus Problems	❒	❒	Due Date: _____		
Recent Weight Gain/Loss	❒	❒	Are you a nursing mother?	❒	❒
History of Drug or Alcohol Abuse	❒	❒	Are you taking birth control pills?	❒	❒
Joint Replacement	❒	❒	Tobacco Use	❒	❒
Pacemaker	❒	❒	Chewing: _____ Smoking: _____		
Replacement of Heart Valves	❒	❒	How much per day: _____		
Stroke	❒	❒	Do you take antacids?	❒	❒

Have you been treated with Biphosphonate drugs? ❒ ❒

Has a physician ever told you to take an antibiotic pre-medication prior to dental treatment? ❒ ❒

Do you consume grapefruit juice, grapefruits or grapefruit extract? ❒ ❒

(Grapefruit affects your body's ability to metabolize medications.)

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

_____

Name & phone number 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:

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Blood Pressure (*for doctor's use only*): _____

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 my next appointment without fail. I consent to whatever dental procedures and anesthetics are necessary for treatment.

Date: _____Signature of patient/parent/guardian: _____

Dental Health Information

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

	YES	NO
Does dental treatment make you nervous?	❒	❒
Is the brightness of your teeth important to you?	❒	❒
Do you drink coffee or tea?	❒	❒
Do you take a fluoride supplement?	❒	❒
Do you think your dental health affects your overall health?	❒	❒
Do you think it is important to have your teeth cleaned at least every six months?	❒	❒
Do you prefer to save your teeth?	❒	❒

Have you noticed any of the following?

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

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:

	YES	NO
Whiter	❒	❒
Straighter	❒	❒
Close space	❒	❒
Replace mercury fillings with tooth colored restorations	❒	❒
Repair chipped teeth	❒	❒
Less gum showing	❒	❒
Replace old crowns or caps that don't match	❒	❒

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

(Please Circle One)

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 1

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?

_____