Please check all that apply:

_____ Tooth Sensitivity (hot, cold, or sweet)
Where: UR LR UL LL
_____ Headaches, earaches or neck pain
_____ Jaw Joint Pain
_____ Teeth or fillings breaking
_____ Grinding or clenching of teeth
_____ Bleeding, swollen or irritated gums
_____ Loose, tipped or shifting teeth
_____ Bad breath

_____ Dentures
_____ Partial dentures
_____ Braces
_____ Periodontal (gum) treatments

Do you smoke or use chewing tobacco? ___ Yes ___No
How much? _____ For how long? _____

If you could change your smile what would be your goal (circle)?
make them whiter
make them straighter
close spaces
replace silver fillings with tooth colored restorations
repair chipped teeth
replace missing teeth
replace old crowns that don't match
have a smile makeover

On a scale of 1-10, with 10 being the highest rating:
- How important is your dental health to you?
1 2 3 4 5 6 7 8 9 10

Name of Prev. Dentist_____ City_____ State____ Ph#_____

MEDICAL HISTORY:

Do you have or ever had any of the following conditions? (CIRCLE ALL THAT APPLY)

Allergies (Seasonal)
Anemia
Arthritis
Artificial Heart Valve
Artificial Joints/Joint Replacement
Asthma
Blood Disease
Bruise Easily
Cancer/Chemo/Radiation Therapy
Diabetes
Dizziness
Drug Addiction
Emphysema
Excessive Bleeding
Fainting
Glaucoma
Heart – Stents
Heart Problems Other
Heart Murmur/Mitral Valve Prolapse
Heart Surgery/Bypass
Hepatitis A B C
High / Low Blood Pressure
Jaundice
Jaw or Joint Pain
Kidney Disease / Dialysis
Liver Disease
Nervous/Depression Disorder/ADD/ADHD
Pacemaker
Pregnant (Currently)
Respiratory Problems
Rheumatic Fever
Rheumatism
Scarlet Fever
Seizures
Stomach Problems
Stroke
Thyroid Disease
Tuberculosis
Ulcers
Venereal Disease
Other _____
_____
_____

Are you allergic or sensitive to any of the following (CIRCLE ALL THAT APPLY)

Aspirin	Amoxicillin	Clindamycin	Codeine	Darvon	Erythromycin
Latex	Local Anesthetic	Nitrous Oxide	Penicillin	Percodan	Sulfa
Tetracycline	Valium	Other:			

Are you under a physician's care? What for? _____

Physician Name and Phone #_____

Medications (please list all) _____

Are you taking blood thinners (other than aspirin)? Yes No

Do you have to Pre-medicate for dental appointment? Yes No

Signature of patient or parent/guardian _____ Date: _____

Patient Name Printed _____