Patient Name	DENTAL HISTORY
Patient Account No.	Medical Alert

Welcome! So that we may provide you with the best possible care please complete both sides of this medical/dental history form. All information is completely confidential.

What is the reason for your visit today? _____

_____

Date of Last Dental Visit_____ **Last Dental Cleaning** _____ **Last Full Mouth X-rays**_____

What was done at your last dental visit? _____

_____

Previous Dentist's Name _____

Address _____ State _____ Zip _____

Telephone_____

How often do you have dental examinations?_____

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

What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? ☐Yes No☐

If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or cold? ☐Yes No☐
Sweets? ☐Yes No☐
Biting or Chewing? ☐Yes No☐
Have you noticed any mouth odors or bad tastes? ☐Yes No☐
Do you frequently get cold sores, blisters or any other oral lesions? ☐Yes No☐
Do your gums bleed or hurt? ☐Yes No☐
Have your parents experienced gum disease or tooth loss? ☐Yes No☐
Have you noticed any loose teeth or change in your bite? ☐Yes No☐
Does food tend to become caught in between your teeth? ☐Yes No☐

If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep? ☐Yes No☐
Bite your lips or cheeks regularly? ☐Yes No☐
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails) ☐Yes No☐
Mouth breathe while awake or asleep? ☐Yes No☐
Have tired jaws, especially in the morning? ☐Yes No☐
Smoke/chew tobacco? ☐Yes No☐

Have you ever had:

Orthodontic treatment? ☐Yes No☐
Oral surgery? ☐Yes No☐
Periodontal treatment? ☐Yes No☐
Your teeth ground or the bite adjusted? ☐Yes No☐
A bite plate or mouth guard? ☐Yes No☐
A serious injury to the mouth or head? ☐Yes No☐

If so, please describe, including cause _____

_____

Have you experienced:

Clicking or popping of the jaw? ☐Yes No☐
Pain? (joint, ear, side of face) ☐Yes No☐
Difficulty in opening or closing the mouth? ☐Yes No☐
Difficulty in chewing on either side of the mouth? ☐Yes No☐
Headaches, neckaches or shoulder aches? ☐Yes No☐
Sore muscles (neck, shoulders)? ☐Yes No☐

Are you satisfied with your teeth's appearance? ☐Yes No☐

Would you like to keep all of your teeth all of your life? ☐Yes No☐

Do you feel nervous about having dental treatment? ☐Yes No☐

If so, what is your biggest concern?

_____

Have you ever had an upsetting dental experience? ☐Yes No☐

If yes, please describe_____

_____

Is there anything else about having dental treatment that you would like us to know? ☐Yes No☐

If yes, please describe _____

_____

_____

(Please complete other side)

Re-order from: Associates Dental Forms (800) 894-0881

Patient Name	MEDICAL HISTORY
Patient Account No.	Medical Alert

1. Have you been under the care of a medical doctor during the past two years? Yes☐ No☐
   If yes, for what? _____
   Physician's Name _____ Phone _____
   Address _____ City _____ State _____ Zip _____
2. Have you taken any medication or drugs during the past two years? Yes☐ No☐
3. Are you taking any medication, drugs or pills now? Yes☐ No☐
   If yes, please list name and dosage _____
4. Have you ever taken prescription medications for weight loss (diet pills)? Yes☐ No☐
   If yes, did you take any of the following:
   Yes☐ No☐ Fen-Phen (Fenfluramine-Phenpermine)
   Yes☐ No☐ Pondimen (Fenfluramine)
   Yes☐ No☐ Redux (Dexfenfluramine)
   If yes to any of the above, did you have a medical exam for heart issues? Yes☐ No☐
5. Are you aware of having an allergic **(or adverse)** reaction to any medication or substance? Yes☐ No☐
   If yes, please list: _____
6. Have you been a patient in the hospital during the past five years? Yes☐ No☐
7. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	Yes☐ No☐	Ulcers	Yes☐ No☐	Hepatitis A (infectious) B (serum)	Yes☐ No☐
Chest Pain	Yes☐ No☐	Diabetes	Yes☐ No☐	Venereal Disease	Yes☐ No☐
Congenital Heart Disease	Yes☐ No☐	Thyroid Problems	Yes☐ No☐	A.I.D.S	Yes☐ No☐
Heart Murmur	Yes☐ No☐	Glaucoma	Yes☐ No☐	H.I.V. Positive	Yes☐ No☐
High Blood Pressure	Yes☐ No☐	Contact lenses	Yes☐ No☐	Cold Sores/Fever Blisters	Yes☐ No☐
Mitral Valve Prolapse	Yes☐ No☐	Emphysema	Yes☐ No☐	Blood Transfusion	Yes☐ No☐
Artificial Heart Valve	Yes☐ No☐	Chronic Cough	Yes☐ No☐	Hemophilia	Yes☐ No☐
Heart Pacemaker	Yes☐ No☐	Tuberculosis	Yes☐ No☐	Sickle Cell Disease	Yes☐ No☐
Rheumatic Fever	Yes☐ No☐	Asthma	Yes☐ No☐	Bruise Easily	Yes☐ No☐
Arthritis/Rheumatism	Yes☐ No☐	Hay Fever	Yes☐ No☐	Liver Disease	Yes☐ No☐
Cortisone Medicine	Yes☐ No☐	Latex Sensitivity	Yes☐ No☐	Yellow Jaundice	Yes☐ No☐
Swollen Ankles	Yes☐ No☐	Allergies or Hives	Yes☐ No☐	Neurological Disorders	Yes☐ No☐
Stroke	Yes☐ No☐	Sinus Trouble	Yes☐ No☐	Epilepsy or Seizures	Yes☐ No☐
Diet (Special/Restricted)	Yes☐ No☐	Radiation Therapy	Yes☐ No☐	Fainting or Dizzy Spells	Yes☐ No☐
Artificial Joints (hip, knee, etc.)	Yes☐ No☐	Chemotherapy	Yes☐ No☐	Nervous/Anxious	Yes☐ No☐
Kidney Trouble	Yes☐ No☐	Tumors	Yes☐ No☐	Psychiatric/Psychological Care	Yes☐ No☐

8. Do you use more than two pillows to sleep? Yes☐ No☐
9. Have you lost or gained more than 10 pounds in the past year? Yes☐ No☐
10. Do you have or have you had any disease, condition, or problem not listed? Yes☐ No☐
    If yes, please list: _____
11. **Women.** Are you: **Pregnant?** ○Yes, ___Months ○No **Nursing?** ○Yes ○No **Taking birth control pills?** ○Yes ○No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may realease such information to you. I will notify the doctor of change in my health or medication.

Patient/Guardian Signature _____ Date _____

History Review

Dentist Signature _____ Date _____

Re-order from: Associates Dental Forms (800) 894-0881

PATIENT INFORMATION AND HEALTH HISTORY

INITIAL EXAM DATE _____

PATIENT'S NAME _____ DATE OF BIRTH _____
SINGLE MARRIED LONG TERM PARTNER DIVORCED SEPARATED WIDOWED

PATIENT'S ADDRESS _____ PHONE _____

PERSON RESPONSIBLE FOR THIS ACCOUNT _____ PHONE _____

ADDRESS _____

EMPLOYED BY _____ BUSINESS PHONE _____

BUSINESS ADDRESS _____ PATIENT'S SS# _____

DENTAL INSURANCE PLAN (IF ANY) _____ REFERRED BY _____

PATIENT'S NAME _____

DENTAL HISTORY

CHIEF ORAL COMPLAINT _____

DATE OF LAST DENTAL EXAM. _____ ANY PREVIOUS MAJOR DENTAL TREATMENT, ☐ YES ☐ NO WHEN _____

_____

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING - INDICATE WITH A (✓)

- ☐ Teeth sensitive to cold, heat, sweets or pressure
- ☐ Bleeding gums. How long _____
- ☐ Food impaction
- ☐ Clenching or grinding
- ☐ Burning of tongue
- ☐ Swelling or lumps in mouth
- ☐ Frequent blisters on lips or mouth
- ☐ Pain around ear
- ☐ Unusual sounds in ear while eating
- ☐ Bad breath
- ☐ Unpleasant taste
- ☐ Unfavorable dental experience
- ☐ Complications from extractions
- ☐ Periodontal treatment
- ☐ Orthodontic treatment
- ☐ Mouth breathing
- ☐ Oral habits, i.e., fingernail biting cheek biting, etc.
- ☐ Cigarettes, pipe or cigar smoking
- ☐ Texture of toothbrush _____
- ☐ Frequency of brushing _____
- ☐ Dental Floss
- ☐ Inter dental stimulators
- ☐ Water jet device
- ☐ Disclosing tablets or solution
- ☐ Fluoride supplements
- ☐ Alcohol

MEDICAL HISTORY

PHYSICIAN'S NAME _____ DATE OF LAST PHYSICAL EXAM. _____ AGE _____

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING - INDICATE WITH A (✓)

- ☐ Allergies to drugs
- ☐ Allergies to anesthetics
- ☐ Any heart ailments
- ☐ High blood pressure
- ☐ Neurological problems
- ☐ Radiation treatments
- ☐ Excessive bleeding from cut or extraction
- ☐ Anemia or blood problems
- ☐ Arthritis
- ☐ Chronic Fatigue Syndrome
- ☐ Asthma
- ☐ Hay fever or allergies in general
- ☐ Diabetes
- ☐ Kidney problems
- ☐ Latex sensitivity
- ☐ Liver problems or hepatitis
- ☐ Malignancies
- ☐ Psychiatric care/emotional problems
- ☐ Rheumatic fever
- ☐ Sinus problems
- ☐ Immune System Disorders (AIDS, HIV, ARC)
- ☐ Stroke
- ☐ Thyroid
- ☐ Eye disorders
- ☐ Tonsilitis
- ☐ Tuberculosis
- ☐ Ulcer or colitis
- ☐ Pregnancy If so, what month _____
- ☐ Venereal disease
- ☐ Other _____

Describe any current medical treatment including drugs taken, even though not listed above _____

_____

APPOINTMENTS: A minimum charge will be made for failed or cancelled appointment without prior notification of 24 hours. This fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still has to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved for you.

INSURANCE: To avoid misunderstandings regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies, upon receipt of full (or partial) payment of bill. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the individual patient.

SIGNATURE _____ DATE _____
(PARENT OR GUARDIAN, IF PATIENT IS A MINOR)