ATIENT NAMEDATE	
Primary reason for this dental appointment: Examination Emergency Consultation	
Dental History	Please Circle
Do you have a specific dental problem? Describe	Yes No
Do you have dental examinations on a routine basis? Last visit	Yes No
Do you think you have active decay or gum disease?	Yes No Yes No
Do you brush and floss on a routine basis? Discuss	Yes No
Do you like your smile? Why?	
Does food catch between your teeth? Any loose teeth?	
Do you want to keep your remaining teeth?	
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind?	Yes No
Have your past experiences in a dental office always been positive?	
Do you smoke or chew? Any sores or growths in your mouth? Discuss	
Name of previous dentist (optional):	
Date of last full mouth x-rays (16 small films or panoramic):	
Medical History	
Are you under a physician's care now? Why? Who? Phone	Yes No
Have you ever been hospitalized or had a major operation? Discuss	Yes No
Have you ever had a serious injury to your head or neck? Discuss	Yes No
Are you taking any medications, aspirin, vitamins, herbals, pills or drugs? What?	Yes No
Are you on a special diet? Discuss	Yes No
Are you allergic to any medications or substances? Please check box below	Yes No
Aspirin Penicillin Codeine Acrylic Metal Latex Rubber Milk Other	
Women (Please check): Pregnant/trying to get pregnant Nursing Taking oral contraceptives Discuss	
Do you now have or have you ever had any of the following? Do you take any of these medicines? Please check appropriate boxes.	
*If yes to any of the starred conditions, please call prior to your appointment premedication or changes in medication may be required.	I.
Yes No Yes No Yes No Yes No	Yes No
Heart Disease/Surgery*	s S S S S S S S S S S S S S S S S S S S
History Review and Significant Findings	
Medical Updates	
I have read my MEDICAL HISTORY dated and confirm that it adequately states past and present or	onditions.
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