PATIENT NAME _____ DATE _____
LAST FIRST M

Primary reason for this dental appointment : _____

DENTAL HISTORY

	PLEASE CIRCLE
Do you have a specific dental problem? Describe : _____	YES NO
Do you have a dental examination on a routine basis? Last visit :_____	YES NO
Would you describe your present dental health as good? Comments :_____	YES NO
Do you think you have active decay or gum disease? _____	YES NO
Do your gums ever bleed? Discuss :_____	YES NO
Do you brush and floss on a routine basis? Discuss :_____	YES NO
Are you aware of clenching or grinding your teeth?_____	YES NO
Is any part of your mouth sensitive to hot /cold or biting/chewing? _____	YES NO
Do you feel nervous about having dental treatment? _____	YES NO
Have you ever had a bad experience in a dental office? Describe :_____	YES NO
Do you want to keep your remaining teeth? _____	YES NO
Do you like your smile? Why? _____	YES NO
Name of previous dentist _____	
Who referred you to our office? _____	

MEDICAL HISTORY

(Confidential. Repeated every five years.)
Height : _____ Weight : _____ Current Age : _____ Birth Date : _____
Medical doctor's name: _____ Date of last physical exam : _____
(Women) Are you pregnant? Yes No Expected delivery date: _____
Are you under a doctor's care now? Yes No If so, for what reason? _____
Are you taking any medications, pills or drugs? Yes No Please list : _____
_____
Have you ever been advised **not** to take any medications? Yes No What med? _____ Why? _____
Have you been advised to take a pre med before dental treatment? Yes No If yes, for what? _____
What med? _____

Have you ever had any of the following? **Indicate YES with check mark (√)**

Any heart problems	Headaches	Diabetes	Hepatitis	Prosthetic valves/joints
High blood pressure	Glaucoma or Cataracts	Arthritis	Aids / HIV Positive	Allergy to anesthetics:
Low blood pressure	Scarlet fever	Malignancies	Venereal Disease	_____
Circulatory problems	Kidney disease	Radiation treatments	Herpes	Allergy to medications/drugs:
Excessive bleeding	Nervous problems	Asthma	Tuberculosis	_____
Anemia	Psychiatric care	Stroke	Sinus problems	Other allergies:
Rheumatic fever	Hospitalization	Ulcer	Tonsillitis	_____
Use of tobacco	Thyroid problems	Frequent indigestion	More than one alcoholic drink per day (# per day : ____)	

Have you ever had any other serious illness? Yes No Explain: _____
Have you been hospitalized in the last two years? Yes No Why? _____
Have you ever had difficulty with anesthetics? Yes No Explain: _____
Do you have any disease, condition or problem not listed above? Yes No Explain: _____
Have you ever had any cosmetic procedure? Yes No If yes, please explain _____
Do you wish to talk to the doctor about any problem not listed? Yes No Comments: _____

AUTHORIZATION: I hereby authorize the doctors and/or staff of the Dental Cosmetic Center to administer such medications and to perform such diagnostic and therapeutic procedures as may be necessary for proper dental care as agreed upon through consultation with me. The information which appears on these dental and medical histories is correct to the best of my knowledge. I will notify the doctor of any changes in my health or medication.

Patient Signature : _____ Date : _____

Reviewed by Doctor : _____ Date : _____ **B/P** _____

MEDICAL UPDATES

Notes :