Dental History Form

PATIENT INFORMATION

First Name

_____

Last Name

_____

Date of Birth

_____

Gender
[ ] Male [ ] Female [ ] Other

Medical Doctor

_____

Doctor City/State

_____

Emergency Contact

_____

Emergency Contact Phone

_____

WHAT IS YOUR IMMEDIATE CONCERN:

_____

Date of most recent treatment (other than cleaning)

_____

	YES	NO
Tobacco Use	[ ]	[ ]

What kind and how much?

_____

I Routinely see my dentist every
[ ] 3 months [ ] 4 months [ ] 6 months [ ] 12 months [ ] Not Routinely

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

	YES	NO
Are you fearful of dental treatment?	[ ]	[ ]

How Fearful, on a scale of 1 (least) 10 (most)

_____

Have you had an unfavorable dental experience?	[ ]	[ ]
Have you ever had complications from past dental treatment?	[ ]	[ ]
Have you ever had trouble getting numb or had any reactions to local anesthetic?	[ ]	[ ]
Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?	[ ]	[ ]

Age

_____

Have you had any teeth removed, missing teeth that never developed, or lost teeth due to injury or facial trauma?	[ ]	[ ]

GUM AND BONE

	YES	NO
Do your gums bleed sometimes or are they ever uncomfortable when brushing or flossing?	[ ]	[ ]
Have you ever been told you have gum disease, or bone loss between your teeth?	[ ]	[ ]
Have you ever noticed an unplesant taste,odor in your mouth, or swollen and puffy gums?	[ ]	[ ]
Is there anyone with a history of periodontal disease in your family?	[ ]	[ ]

PERSONAL HISTORY

NEW PATIENTS

Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 5 years old?

_____

Do you have annual x-rays that are less than 1 year old?

_____

Date of last cleaning and exam

_____

Former Dentist

_____

Dentist City/State

_____

LIST ANY MEDICATIONS THAT YOU ARE NOW TAKING:

Medication	Dosage / Frequency

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Other allergies not listed above

_____

Has a physican or previous dentist recommened that you take Antibotics before having dental work done?

_____

DO YOU HAVE ANY OF THE FOLLOWING MEDICAL CONDITIONS?

Other conditions not listed above

_____

ARE YOU:

	YES	NO
Aware of a change in your health in the last 24 hours (e.g. fever,chills,new cough, or diarrhea)	[ ]	[ ]
Presently being treated for any illness?	[ ]	[ ]
Taking medication for weight management	[ ]	[ ]
Often unhappy or Depressed?	[ ]	[ ]
Taking dietary supplements, vitamins, and/or probiotics?	[ ]	[ ]
Experincing frequent headaches or chronic pain?	[ ]	[ ]

Describe any current medical treatment, impending surgery, developmental delay, or other treatment that may possibly affect your dental treatment

_____

Signature _____ Date _____