Patient Name

DENTAL HEALTH HISTORY

The information you provide is important for your dental health. If there have been any changes in your health, ***please tell us***.

If you have any questions, do not hesitate to ask. Please answer ***Yes or No*** to the following questions:

Are you having discomfort? ☐ Yes ☐ No
Any sensitivity to hot, cold, sweets, chewing? ☐ Yes ☐ No
Does dental treatment make you nervous? ☐ Yes ☐ No

Are your teeth turning yellow or loosing brightness? ☐ Yes ☐ No
Do you smoke? ☐ Yes ☐ No
Do you drink coffee or tea? ☐ Yes ☐ No

Have you experienced any of the following problems?

- ☐ Snoring Problem
- ☐ Bleeding Gums
- ☐ Bad Breath
- ☐ Grinding Teeth
- ☐ Mouth Guard for Athletes
- ☐ Other

- ☐ Arthritis
- ☐ Difficulty in Reaching Back Teeth
- ☐ Uncontrolled Hand Movement
- ☐ Other

If I could change my smile I would make my teeth:

- ☐ Whiter
- ☐ Close Space
- ☐ Replace Stained Front Filling
- ☐ Change Silver Filling to White
- ☐ Repair Chipped Teeth
- ☐ Other

- ☐ Do You Take Fluoride Supplement?
- ☐ Do You Prefer to Save Your Teeth?
- ☐ Have You Had A Special Coating Applied to Your Back Teeth to Protect From Tooth Decay?
- ☐ Other

Date of your last Cleaning

Have you ever had Periodontal Therapy done? ☐ Yes ☐ No

Denture and Partial Patients

Do you wear a Denture/Partial? ☐ Yes ☐ No
How old is your Denture/Partial? Years

Have you relined your Dentures before? ☐ Yes ☐ No
Does your denture cause any irritation/soreness? ☐ Yes ☐ No
Have your dentures ever broken or cracked? ☐ Yes ☐ No

If you wear a partial, did you ever break a Clasp? ☐ Yes ☐ No
Do you use Denture Cleaner? ☐ Yes ☐ No
Do you use any denture adhesive? ☐ Yes ☐ No
Do you use any product to prevent denture odor? ☐ Yes ☐ No
Are your dentures loose? ☐ Yes ☐ No

Please explain reason for your visit to our office today

How many times a day do you brush?

How many times a week do you floss?

What type of toothbrush bristles do you use**?**

In a Scale of 1 to 10 *(Being 10 the Best)* How would you rate your smile?

Document Signature Field

Patient Name

MEDICAL HISTORY

Name of Physician

Physician's Number

Name of Previous Dentist

Reason for Leaving

Date of Last Visit of Physician

HEART PROBLEMS

- ◯ Chest Pain
- ◯ Shortness of Breath
- ◯ Blood Pressure Problems
- ◯ A Heart Murmur
- ◯ Heart Valve Problem
- ◯ Taking Heart Medication
- ◯ Rheumatic Fever
- ◯ Pacemaker
- ◯ Artificial Heart Valve

List Other

BLOOD PROBLEMS

- ◯ Easy Bruising
- ◯ Frequent Noise Bleeding
- ◯ Abnormal bleeding
- ◯ Blood disease (anemia)

ALLERGY PROBLEMS

- ◯ Hay Fever
- ◯ Sinus Problem
- ◯ Skin Rashes
- ◯ Taking Allergy Medication
- ◯ Asthma

INTESTINAL PROBLEMS

- ◯ Ulcers
- ◯ Weigh Gain or Loss
- ◯ Back or neck pain
- ◯ Constipation

BONE OR JOINT PROBLEMS

- ◯ Arthritis
- ◯ Back or neck pain
- ◯ Joint Replacement
- ◯ Pins or metal rods

Doctor Signature after review

- ◯ Fainting, Spell, Seizures, Epilepsy
- ◯ Diabetes
- ◯ Tuberculosis or Other Respiratory Disease
- ◯ Cancer Tumor
- ◯ Hepatitis, Jaundice or Liver Problem
- ◯ Herpes
- ◯ HIV Positive / AIDS
- ◯ Glaucoma
- ◯ Have you been Hospitalized during the past five years?
- ◯ Do you have any disease, problem or condition not listed?
- ◯ Do you have any psychiatric problems?

During the past 12 months, have you taken any of the following?

- ◯ Antibiotics or Sulfa Drugs
- ◯ Anticoagulants
- ◯ High blood pressure medicine
- ◯ Tranquilizers
- ◯ Insulin, Ironies or similar drug
- ◯ Aspirin (Daily)
- ◯ Digitals or drugs for heart problems?
- ◯ Nitroglycerine
- ◯ Cortisone (Steroids)

List Meds you take every day

WOMAN

- ◯ Taking Contraceptives?
- ◯ Other Hormones?
- ◯ Pregnant?

Delivery Date?

ARE YOU ALLERGIC TO THE FOLLOWING?

- ◯ Local Anesthetics
- ◯ Penicillin or other Antibiotics
- ◯ Sulfa Drugs
- ◯ Barbiurates, sedatives, or sleeping pills
- ◯ Codeine

PATIENT INFORMATION

Last Name

First Name

Initial

Address

City

State Alabama

Zip Code

Country

Home Phone #

E-mail

Cell Phone #

Employer

Work Phone #

Emergency Contact

SSN

Contact Phone #

Patient DOB

DENTAL INSURANCE POLICY HOLDER

Ins. Company Name

Insurance Phone #

Insured Name

Id Number

Insured DOB

Insured's Employer

◯ I herby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand that I am solely responsible for any balance not paid by my insurance company.

◯ Bay Indies News Letter
◯ Clipper Magazine
◯ Drive-By
◯ Verizon Yellow Pages
◯ Friend / Relative
◯ Historical Publishing
◯ Insurance Company
◯ Embarq Yellow Pages
◯ Physician and Medical Guide
◯ Sign age
◯ Style Magazine
◯ Yellow Book
◯ Television
◯ Value Pack
◯ Venice Gulf Coast Living
◯ Advantage Yellow Pages
◯ Venice Best Value
◯ Venice Gondolier
◯ Welcome Wagon
◯ Russian Yellow Pages
◯ Florida Health care news
◯ Internet
◯ Treasure Chest

How do you want to be contacted for appointment reminders?

◯ Home Phone
◯ Work Phone
◯ Cell Phone
◯ E-Mail
◯ Text Message
◯ Mail to address

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

Print Form

Current Date 3/26/08

Reset Form