New Patient Medical and Dental History

Name:_____ Date of Birth:_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry that you will be receiving. Thank you for answering the following questions.

Are you in good health? ____ Date of your last physical exam: _____ Are you under the care of a physician now? _____ Do you bruise easily?_____ Do you smoke or use smokeless tobacco?_____
Physician's Name:_____
Phone:_____
Please list ALL medications that you are taking:
_____
_____
_____

Please check if you are you allergic to:

__Aspirin __Barbiturates __Codeine __Iodine __Latex

__Local Anesthesia __Metals __Penicillin __Sulfa __Other

_____

Please check if you have or ever had any of the following:

Heart	**Lung**	**Digestive**
__Defect	__Asthma	__Stomach ulcers
__Murmur	__Tuberculosis	__Acid reflux
__Attack	__Hay fever/Seasonal allergies	__Eating disorder
__Mitral Valve Prolapse	__Persistent cough that produces blood	
__Pacemaker		
__Angina		
__High/Low Blood Pressure		
__Rheumatic Fever		

Please check if you have a history of any of the following:

__AIDS/HIV infection	__Epilepsy/Seizures	__Mental Health Care
__Anemia	__Glaucoma	__ Sexually Transmitted Disease
__Arthritis/Rheumatism	__Hepatitis, Type___	__ Stroke
__Back/Neck Problems	__Hypoglycemia	__Thyroid Problems
__Cancer/Chemotherapy	__Joint Replacement	__Tonsillitis
__Diabetes, Type___	__Kidney Problems	__Vertigo

Women:

__Are you pregnant or think you may be pregnant? If so, when is your due date? _____
__Are you nursing?
__Are you taking birth control pills?

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Reason for your visit_____
When was your last dental exam and cleaning?_____
Did you have a series of dental films taken at that time?_____
How often did you visit your dentist before then?_____
Name of your previous dentist and phone number_____
How often do you brush your teeth?_____ How often do you floss?_____
Is your drinking water fluoridated?_____

Please check if any of the following pertains to you:

__Do your gums bleed while brushing or flossing your teeth?
__Are your teeth sensitive to hot or cold food/fluids?
__Are your teeth sensitive to sweet or sour food/fluids?
__Do you feel any pain in your teeth?
__Do you have any sores or lumps in or near your mouth?
__Have you had any head, neck or jaw injuries?
__Do you have frequent headaches?
__Do you clench or grind your teeth?
__Do you bite your lips or cheeks frequently?
__Have you ever noticed any loosening of your teeth?
__Does food get caught in between your teeth?
__Have you ever had periodontal treatment (gums)?
__Have you ever worn a night guard or any other appliance?
__Have you ever had any difficult extractions in the past?
__Do you wear dentures or partials? If so, date of placement._____
Have you ever experienced any of the following problems in your jaw?
- __Clicking
- __Pain (joint, ear or side of face)
- __Difficultly in opening or closing
- __Difficultly in chewing

If you could change anything about your smile, what would you change?
_____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the denist or otherwise payable to me. I understand that dental insurance carriers may pay less then the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

Signature of patient, parent or guardian **Date**

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