DENTAL HEALTH HISTORY

PATIENT'S NAME:_____ BIRTHDATE:_____
LAST FIRST MIDDLE INITIAL

Reason for today's visit:_____

Former Dentist:_____ Reason for Leaving:_____ Date of last dental care_____ Last dental x-rays_____

Check ( ) if you have had problems with any of the following:

____Bad breath
____Bleeding gums
____Clicking or popping jaw
____Food collection between teeth
____ Chipped or broken teeth
____ Grinding teeth
____ Loose teeth or broken fillings
____ Periodontal treatment
____ Sensitivity to cold
____ Sensitivity to hot
____ Sensitivity to sweets
____ Sensitivity when biting
____ Sores or growths in mouth

How often do you floss? _____ How often do you brush? _____ Do you smoke?_____
Do you take any herbs?_____ Name the herbs you take _____
Have you had any side effects from herbs?_____ Explain_____

Our office, **upon recommendation of the American Dental Association**, applies Topical Fluoride **every 6 months** to aid in the prevention of tooth decay**, through the age of 12 years. Most dental insurance companies will cover this procedure once a year**. Please check one box and sign:

____ **Yes**, I understand and give my consent to the application of Fluoride **every 6 months.**
____ **No**, I refuse the application of Fluoride every 6 months as recommended by the American Dental Association.

MEDICAL HISTORY

Physician's name_____ Date of last visit_____

Have you had any serious illnesses or operations? _____ Describe_____

Have you ever had a blood transfusion? Yes____ No____ if yes, give approximate date_____

(Women) Are you pregnant Yes____ No____ Nursing? Yes___ No___ taking birth control pills? Yes____ No____

Check ( ) if you have had any of the following:

____ AIDS
____ Anemia
____ Arthritis, Rheumatism
____ HIV positive
____ Jaw pain
____ Artificial Joints
____ Asthma
____ Back Problems
____ Blood Disease
____ Cancer
____ Chemical Dependency
____ Chemotherapy
____ Circulatory Problems
____ Cortisone Treatments
____ Cough, Persistent
____ Cough up blood
____ Shortness of breath
____ Skin rash
____ Epilepsy
____ Fainting
____ Glaucoma
____ Headaches
____ Heart Murmur
____ Heart Problems
Describe:_____
____ Hemophilia/Excessive bleeding
____ Hepatitis
____ High blood pressure
____ High Cholesterol
____ Artificial Heart Valves
____Migraines
____ Kidney disease
____ Liver disease
____ Mitral Valve Prolapse
____ Nervous Problems
____ Pacemaker
____ Psychiatric Care
____ Radiation Treatment
____ Respiratory Disease
____ Rheumatic Fever
____ Scarlet Fever
____ ADD/ADHD
____ Diabetes
____ Reflux
____ Stroke
____ Swelling feet/ankles
____ Thyroid problems
____ Tobacco habit
____ Tonsillitis
____ **Tuberculosis**
____ Ulcer
____ Venereal disease

MEDICATIONS

List medications you are taking:_____
_____
_____
_____

ALLERGIES

____ Aspirin
____ Barbiturates (Sleeping Pills)
____ Codeine
____ Local anesthetic
____ Penicillin
____ Sulfa drugs
____ Other_____
_____

SIGNATURE

The above information is complete and accurate to the best of my knowledge. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

DATE:_____ **SIGNATURE:**_____