Patient Name: ____ Date: _________________________

When was your last dental visit? __________________ Name of previous dentist_______________________________

Why did you leave your last dentist? ____

What is the most important thing to you about your smile and dental health? ___________________________________

Are there any areas of concern you would like to address today? ____

On a scale of 1-10, with 10 being the highest :

How important is your dental health to you? _________ How would you rate your current dental health? _________

Please check any of the following that apply to you :

	Condition
	ADD/ADHD
	AIDS/HIV
	Allergies
	Anxiety
	Anemia
	Artificial Heart Valve
	Artificial Joints
	Asthma
	Autism- Mild Severe
	Behavioral Problems
	Birth Defects
	Blood Disease
	Brain Injury
	Bruise Easily
	Cancer type:
	Chemical Dependency
	Chemotherapy
	Chicken Pox
	Child Abuse
	Cleft Palate/Lip
	Cold Sore/Canker Sore
	Developmentally Delayed: Age level is
	Depression
	Diabetes

	Condition
	Heart Condition
	Heart Murmur
	Hemophilia
	Hepatitis A B C
	High Blood Pressure
	Hospital Stay/Operation:
	Injury to Front Teeth
	Kidney Disease
	Liver Disease
	Low Blood Pressure
	Lupus
	Mentally Handicapped
	Metallic Implant, Shunts, Pins, Rods
	Mitral Valve Prolapse
	Mononucleosis
	Pacemaker
	Psychiatric Care
	Radiation Head Neck Other:
	Recreational Drugs
	Rheumatic Fever
	Rheumatism
	Scarlet Fever
	Seizures type:
	Sleep Apnea

	Are you Allergic to:
	Aspirin
	Codeine
	Erythromycin
	Latex
	Local Anesthetic
	Nitrous Oxide
	Penicillin
	Food
	Other

	For Women
	Birth Control
	Breast Feeding
	Pregnant
	1st 2nd 3rd trimester

	Do you have or have you had any of the following:
	Sensitivity -hot, cold, sweet
	Headaches
	Neck or jaw joint pain
	Grinding or clenching teeth
	Bleeding or swollen gums
	Loose or shifting teeth

	Dizziness/Fainting		Sore Throats		Bad Breath
	Down Syndrome		Speech Impairment		Partials or Dentures
	Earaches/Infection		Stomach Problems		Deep cleaning
	Eye Conditions		Thyroid Disease		Braces
	Excessive Bleeding		Tuberculosis		
	Hearing Impairment		**None**:		

If you answered yes to any of these questions or have any other conditions, please explain: ____

Do you smoke or use chewing tobacco? Y/N How much?__________ For how long? ____________

Are you under a physician's care? Y/N For What? ______________________________ Physician: ____________________

Please list any medications you are taking ____

Is there any other Medical or Dental information we should know? ____

Patient Signature ____
Date:____________________

Team Member _________