

Dental History

Reason for today's visit _____

Date of last dental exam _____

Former Dentist _____

Date of last x-rays _____

<u>Condition</u>	<u>Don't</u>			<u>Condition</u>	<u>Don't</u>			<u>Condition</u>	<u>Don't</u>		
	<u>Yes</u>	<u>No</u>	<u>Know</u>		<u>Yes</u>	<u>No</u>	<u>Know</u>		<u>Yes</u>	<u>No</u>	<u>Know</u>
Bad breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Periodontal (gum) treatment/surgery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loose/broken teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Biting of lips/cheeks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Scaling/root planing (deep cleaning)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loose/broken filling(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fingernail biting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gums bleeding/tender/swollen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to hot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Clicking/popping of jaw	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty opening/closing jaw	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain/discomfort of jaw	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Food collection between teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to sweets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sores or growths in mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cigarette/cigar/pipe smoking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sensitivity to biting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Orthodontic treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Grinding/clenching of teeth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

How often do you brush? _____

How often do you floss? _____

Have you had any serious/difficult problems associated with any previous dental treatment? No Yes

Medical History

Physician's Name: _____

Date of last visit _____

<u>Condition</u>	<u>Don't</u>			<u>Condition</u>	<u>Don't</u>			<u>Condition</u>	<u>Don't</u>		
	<u>Yes</u>	<u>No</u>	<u>Know</u>		<u>Yes</u>	<u>No</u>	<u>Know</u>		<u>Yes</u>	<u>No</u>	<u>Know</u>
AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis/rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valve	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial joints	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Special diet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis Type _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen feet/ankles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bisphosphonate treatment (Zometa or Aredia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen neck glands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding abnormally, with surgery/extraction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jaw pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chemical dependency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tumor or growth on head or neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Circulatory problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Venereal disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart lesions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervous problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Weight loss/unexplained	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone treatments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nursing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you wear contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cough, persistent/bloody	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pregnant, due _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Radiation treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Respiratory disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Medications

List any medications you are currently taking: _____

Pharmacy Name _____

Location _____ Phone _____

Allergies

<u>Yes</u>	<u>No</u>	<u>Don't Know</u>	<u>Condition</u>	<u>Yes</u>	<u>No</u>	<u>Don't Know</u>	<u>Condition</u>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Barbiturates	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Codeine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Iodine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Latex				_____

To Be Completed By Patient

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

 Signature of Patient (Legal Guardian/Custodian if minor)

To Be Completed By Attending Doctor

The dental and medical history outlined on this registration form by our patient or their duly authorized representative has been reviewed by myself and any conditions that could/would be affected by dental treatment has been identified and discussed.

 Signature of Attending Doctor

 Date