## **DENTAL HISTORY**

Please check any of the following problems that apply to youSensitivity (hot; cold, sweet, pressure)	Yes	No		If you could whiten your te anyone could afford, would Do you smoke or use chew	l you do it?		Yes	No		
Where? UR LR UL LL				How much?	For how 1	ong?	_			
-Headaches, earaches, neck pain -Jaw joint pain -Teeth or fillings breaking -Grinding or clenching teeth -Bleeding, swollen or irritated gums -Loose, tipped or shifting teeth -Bad breath				If I could change my smileMake it whiter -Make it straighter -Close spaces -Replace black metal fill colored restorations	I would:					
Do you have or have you had any of the following? -Dentures -Partial dentures -Braces				-Repair chipped teeth -Replace missing teeth -Replace old crowns that -Have a smile makeover						
-Periodontal (gum) treatments				ON A SCALE OF 1-10, V How important is your deni			IGHE	ST RATI	NG:	
Please share the following dates: -Your last cleaning -Your last oral cancer screening -Your last complete X-Rays	_/			1 2 3 4 Where would you rate your 1 2 3 4 Where do you want your do	5 current den	6 7 ntal health? 6 7	8	9 9	10 10	
Name of Previous Dentist					5		8	9	10	
CityState				Why did you leave your pro						
Phone Number										
What is the most important thing to you about your fu	iture smile	and o	dental hea	llth?						
What is the most important thing to you about your de										
	MF	CDI	ICAI	HISTORY						
- Have you taken antibiotics prior to dental appoi - Are you currently taking any blood thinners?				Yes [	No □					
Please check any of the following problems/cond	litions tha	t app	ly to you	:						
AIDS	leeding tions as (Congenit ur ry	C		HIV Positive HPV (Human Papilloma virus) Jaundice Jaw Joint Pain Kidney Disease Liver Disease Low Blood Pressure Mitral Valve Prolapse Nervousness/Depression Pacemaker Pregnant Currently Radiation (head/neck) Respiratory Problems Rheumatic Fever Rheumatism		Scarlet Feve Seizures Sinus Proble Sleep Apne Stomach Pr Stroke Thyroid Dise Tuberculosi Ulcers Venereal Di Other	ems a roblem ease s	ns		
Are you allergic or have you reacted adversely to YES NO YES Aspirin Percodan Darvon Latex Ditrous Oxide Local Anesthetic	NO T	etrac odeir	ycline [	es no yes 	NO C	Other				
Have you ever taken any the following medication			Are you	under a physician's care?	What for?					
YES NO YES NO				What medications are you currently taking?						
Aredia	]		Family F	Physician	Phone Number					
Consent: The undersigned herby authorizes Doctor to take X-ray thorough diagnosis of the patient's dental needs. I also I also understand the use of anesthetic agents embodie	authorize	Docto	or to perfo	rm any and all forms of treatn	nent, medic	ation and thera	py tha	etor to ma t may be	ke a indicated	
Patient Signature (Parent if child)			Date	Dentis	t Signature					