



## Dental History

What are your main concerns about your teeth? \_\_\_\_\_

Y or N Have you consulted with or been treated by an orthodontist previously?  
How long did you wear braces? \_\_\_\_\_ At what age was your treatment? \_\_\_\_\_

Y or N Have you ever had a serious/difficult problem with dental treatment?

Y or N Do you clench or grind your teeth? (circle)

Y or N Have you ever had an injury to your head, neck, or face? Tell us about it. \_\_\_\_\_

Y or N Do you have speech problems or a tongue thrust (circle)?

Y or N Do you breathe through your mouth? While awake or while asleep? (circle)

Y or N Have you ever had any popping, clicking or pain in your jaw joints (TMJ)? (circle)

Y or N Do you experience frequent headaches?

Y or N Have you been informed of missing or extra permanent teeth?

Y or N Do you require antibiotics before dental treatment?

## Medical History

Please circle if you have or had any of the following:

- |                                |                                 |                              |
|--------------------------------|---------------------------------|------------------------------|
| Y or N Arthritis               | Y or N ADD/ADHD                 | Y or N Allergies to Drugs    |
| Y or N Allergy to latex/metals | Y or N Allergic to Plastic      | Y or N Any Hospital Stays    |
| Y or N Any Operations          | Y or N Artificial Joints/Valves | Y or N Asthma                |
| Y or N Anemia                  | Y or N Blood transfusion        | Y or N Cancer                |
| Y or N Convulsions/Epilepsy    | Y or N Congenital Heart Defect  | Y or N Diabetes              |
| Y or N Handicaps/Disability    | Y or N Hearing Impairment       | Y or N Heart Murmur          |
| Y or N Hepatitis               | Y or N HIV+ or AIDS             | Y or N Kidney Problems       |
| Y or N Herpes/Fever Blisters   | Y or N Liver Problems/Jaundice  | Y or N Lupus                 |
| Y or N Emotional Problems      | Y or N Tuberculosis (TB)        | Y or N Abnormal Bleeding     |
| Y or N High Blood Pressure     | Y or N Heart Attack/Stroke      | Y or N Heart Surgery         |
| Y or N Mitral Valve Prolapse   | Y or N Radiation Treatment      | Y or N Shingles              |
| Y or N Sinus Problems          | Y or N Ulcers/Colitis           | Y or N Sickle Cell Disease   |
| Y or N Rheumatic/Scarlet Fever | Y or N Venereal Disease         | Y or N Psychiatric Treatment |

Y or N Are you currently under the care of a physician?

Y or N Have you ever taken Phen-Fen (also known as Redux or Pondimin)?

Please list all medications you are currently taking: \_\_\_\_\_

Please list all medications, etc. that you are allergic or sensitive to: \_\_\_\_\_

Physician \_\_\_\_\_ Phone # \_\_\_\_\_

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services that I may need during diagnosis and treatment with my informed consent.

**Signature of Patient**

**Date**

This office reserves the right to verify credit status of potential patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting agencies.

**Signature of Patient**

**Date**

**OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY**

I verbally reviewed the medical/dental information above with patient named herein.

Initials \_\_\_\_\_ Date \_\_\_\_\_ Comments: \_\_\_\_\_