Medical History

Name:___________________________ Date of Birth:__________________________
Name of personal physician:____
Physician's phone number:________________________ Date of last visit:________________________

Health Information

Current Health: Excellent Good Fair Poor
Do you smoke or use chewing tobacco? Yes No If yes, how much per day?_________________________
Date of last dental visit:____________________ Reason for this visit:_________________________________

Current Health: Excellent Good Fair Poor
Do you smoke or use chewing tobacco? Yes No If yes, how much per day?_______________________
Date of last dental visit:____________________ Reason for this visit:_________________________________
Have you ever had any of the following?
Y N AIDS Y N Fainting Y N Nervous Disorders Y N Ulcers
Y N Allergies Y N Glaucoma Y N Pacemaker Y N Venereal Disease
Y N Anemia Y N Growths Y N Pregnancy Y N Codeine Allergy
Y N Arthritis Y N Hay Fever Due Date:__________ Y N Penicillin /Sulfa Allergy
Y N Artificial Joints Y N Heart Disease Y N Head Injuries Y N Radiation Treatment
Y N Asthma Y N Heart Murmur Y N Respiratory Problems Y N Rheumatism
Y N Blood Disease Y N Hepatitis Y N Sinus Problems Y N Stomach Problems
Y N Cancer Y N High Blood Pressure Y N Stroke Y N Tuberculosis
Y N Diabetes Y N Jaundice Y N Tumors Y N Taken Fen-Phen
Y N Dizziness Y N Kidney Disease Y N Latex Allergy Y N Excessive Bleeding
Y N Epilepsy Y N Mental Disorders Other:____
Have you ever been admitted to a hospital or needed emergency care during the past two years? Y N
If yes, please explain:____
Are you now under the care of a physician? Y N
If yes, what for?____
Are you taking any medications (including herbal)?
If yes, please list____
Do you have any health problems that need further clarification? Y N
If yes, please explain:____

Dental History

Have you ever had any complications following dental treatment? Y N
If yes, please explain:____
Many patients consult us for a second opinion. Have you seen another dentist for your needs? Y N
How would you describe the condition of your teeth and gums? Good Fair Poor
Are you currently in pain or discomfort with your teeth and gums? Yes No
If yes, please explain:____
Previous Dentists Name:________________________________ Phone:_______________________________
If you could wave a magic wand and change anything about the appearance of your smile, what would you like to do?____
If you could easily and safely whiten your teeth, would you be interested? Yes No
Please RANK the following in the order of which they would KEEP YOU from having dental treatment:
___FEAR of pain ___COST of treatment ___LACK of concern ___MISSING work time
How often do you brush your teeth?_________________________ Floss your teeth?_____________________
Do your gums bleed when you brush your teeth? Yes No Floss your teeth? Yes No
Have you ever experience pain in your jaw? Yes No Do you grind your teeth? Yes No

Have you ever been treated for TMJ symptoms? Yes No
If yes, please explain: ____revised

The preceding information is correct to the best of my knowledge. I understand it will be held in the strictest of confidence and only be used to improve communication between the Doctor and myself. I also give permission for the Doctor or his staff to use any photos he may take for lecturing or education purposes.
Signature:____________________________________ Date:______________________________