*Patient Name*_____, *Age*_____*Date*_____

Reason for seeking care today: ☐ Exam ☐ Cleaning ☐ Specific problem_____

Please check all that apply:

___Gums bleed
___Broken filling or tooth
___Food catches
___Loose teeth
___Floss breaks easily or hurts
___Bite or teeth have shifted
___Often bite cheeks
___Frequent dry mouth
___Concerned about breath
___Unhappy with previous dental work
___Tooth ache
___Gums tender
___Growths, sores
___Cold sore, blisters
___Cracked/chapped lips

Sensitivity to: ___Cold ___Hot ___Sweets
___Chewing
___Previous bite treatment
___Bad taste in mouth
___Sinus problems ___Mouth breathe--Difficulty breathing thru nose
___Dry or strained eyes
___Shoulder, neck or head aches
___Clench or grind teeth
___Jaw joint pain
___Clicking or popping of joint
___Jaw gets tired easily
___Unable to open mouth wide
___Hold things between teeth
___Bite fingernails
___Unusual habits with teeth
___Wore braces
___Previous gum treatment

Would you like whiter teeth?_____ Is there anything that bothers you about the appearance of your teeth or smile?_____
Please rate how anxious you are about dental treatment (1=totally relaxed)_____
Have you ever had a bad experience at the dentist? (Treatment? Staff? Billing?)_____
Why did you leave your previous dentist?_____
Did your parents have difficulties with their teeth or dental treatments?_____

Medical History

Physicians Name:_____
City_____Phone_____
Have you been hospitalized for any reason?
Please describe_____
Are you taking any medications or drugs
(including nutritional supplements?)_____
_____

Are you allergic to penicillin, aspirin, latex, sulfa, local anesthetics, codeine, other?_____
Do you smoke? How much/day_____
Pregnant?___Due Date_____Nursing?_____
Are you seeing a physician now or planning to see one for any reason? Please explain:_____
_____

Please check all that apply:

__Previous injury to head or neck
__Heart problem
__Heart attack
__Angina, chest pain
__Heart murmur
__Scarlet, Rheumatic fever
__Mitral valve prolapse
__Irregular heartbeat
__High or low blood pressure
__Pacemaker __Asthma
__Artificial joint
__Sickle cell
__Diabetes
__HIV or AIDS
__Kidney problem
__Liver problem, jaundice
__Cirrhosis, hepatitis
__Cancer
__Radiation, Chemo
__Respiratory problem
__Bloody cough
__Emphysema __Hives, rash, herpes
__Anemia
Any other illness not listed_____
__Digestive problem, ulcer
__Thyroid disease
__Glaucoma
__Bleed or bruise easily
__Stroke
__Epilepsy or seizures
__Parkinson's
__Alzheimer's
__Back problems
__Dry eyes
__Shortness of breath
__Snoring, sleep apnea
__Easily winded
__No energy
__Fainting or dizzy
__Unexplained weight loss
__Chewing tobacco
__Drug or alcohol addiction
__2 or more social drinks/day
__Anxiety or nervous disorder
__Insomnia

Please indicate if you would prefer to speak privately with the dentist about a medical issue? __Yes __No

Please rate the following indicators of your daily stress level: 1-10: (1=low, 10=high)
__Overworked, too busy, pressured __Feel frustrated __Get upset, or "snap" easily __Depression, anxiety

I will inform this office of any changes in my health status. I understand that dental treatment and local anesthesia entail risks such as bleeding, infection, nerve damage, or fracture of teeth or bone. I certify that the above information is complete and accurate to the best of my knowledge.

Patient Signature (parent or guardian)_____Date_____