DENTAL HISTORY FORM

Patient Name _____

Date of last Dental Visit _____

Primary Reason for Today's Visit _____ Date of last Dental X-Ray _____

Name of Former Dentist _____ Telephone (_____) _____-_____

Is this office visit for Emergency Dental Care? ☐ Yes ☐ No If yes, explain: _____

1. Have you ever had a local anesthetic (Novocaine, etc.)? **Yes No**
2. Have you ever had any unfavorable reactions from a local anesthetic? **Yes No**
3. Have you had any serious complications associated with any previous dental treatment? **Yes No**
   If yes, please explain? _____
4. Have you had any unhappy/unpleasant dental experience? **Yes No**
   If yes, please explain? _____
5. Have you had any orthodontic treatment? **Yes No**
6. Do you currently have any dental implants, dentures, or partials? **Yes No**
7. Do you easily gag? **Yes No**
8. Does your jaw get "stuck," "locked," or "go-out"? **Yes No**
9. Do you have any oral habits (thumb sucking, nail biting or biting on foreign objects – pencils, etc.)? **Yes No**
10. Does dental treatment make you nervous? ☐Slightly ☐Moderately ☐Extremely

Have you ever suffered from, or been told you may have one of the following? (Please check ✔all that apply)

- ☐ Gum Disease
- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Pain in or near your ears
- ☐ Tooth Sensitivity to Hot/Cold
- ☐ Grinding or Clenching
- ☐ Clicking/Popping Jaw
- ☐ Dry mouth
- ☐ Mouth breathing
- ☐ Jaw Pain/ TMJ Pain
- ☐ Headaches or Migraines
- ☐ Malocclusion
- ☐ Difficulty Swallowing
- ☐ Sore Throat
- ☐ Pain in the Mouth
- ☐ Sores/Growth in the Mouth
- ☐ Snoring
- ☐ Sleep Apnea

The most important concerns regarding my dental treatment are: _____

Any additional comments/questions: _____

_____

I have reviewed the information on this questionnaire and it is accurate and complete to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate dental treatment.

Signature _____ ***Date*** _____

CONSENT FOR TREATMENT:
I hereby grant authority to the dentist(s) in charge of the care of the patient, whose name appears on this health history form, to administer such anesthetics, analgesics, nitrous oxide sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics, and/or drugs.

Patient/Guardian Signature _____ ***Date*** _____
Relationship to Patient (If patient is a minor) _____

MEDICAL HISTORY UPDATE

UPDATE 1 - Since your last visit:

1. Have you seen a medical doctor? ☐ **Yes** ☐ **No**
2. Have you had a change in your medication? ☐ **Yes** ☐ **No**
3. Have you had a change in your medical condition or had surgery? ☐ **Yes** ☐ **No**
4. Are there any changes in health since your last visit? ☐ **Yes** ☐ **No**

If yes, what changes? _____

Patient Signature _____ *Date* _____

Relationship to patient (if patient is a minor) _____

Reviewed by Dr. _____

UPDATE 2 - Since your last visit:

1. Have you seen a medical doctor? ☐ **Yes** ☐ **No**
2. Have you had a change in your medication? ☐ **Yes** ☐ **No**
3. Have you had a change in your medical condition or had surgery? ☐ **Yes** ☐ **No**
4. Are there any changes in health since your last visit? ☐ **Yes** ☐ **No**

If yes, what changes? _____

Patient Signature _____ *Date* _____

Relationship to patient (if patient is a minor) _____

Reviewed by Dr. _____

UPDATE 3 - Since your last visit:

1. Have you seen a medical doctor? ☐ **Yes** ☐ **No**
2. Have you had a change in your medication? ☐ **Yes** ☐ **No**
3. Have you had a change in your medical condition or had surgery? ☐ **Yes** ☐ **No**
4. Are there any changes in health since your last visit? ☐ **Yes** ☐ **No**

If yes, what changes? _____

Patient Signature _____ *Date* _____

Relationship to patient (if patient is a minor) _____

Reviewed by Dr. _____

UPDATE 4 - Since your last visit:

1. Have you seen a medical doctor? ☐ **Yes** ☐ **No**
2. Have you had a change in your medication? ☐ **Yes** ☐ **No**
3. Have you had a change in your medical condition or had surgery? ☐ **Yes** ☐ **No**
4. Are there any changes in health since your last visit? ☐ **Yes** ☐ **No**

If yes, what changes? _____

Patient Signature _____ *Date* _____

Relationship to patient (if patient is a minor) _____

Reviewed by Dr. _____

UPDATE 5 - Since your last visit:

1. Have you seen a medical doctor? ☐ **Yes** ☐ **No**
2. Have you had a change in your medication? ☐ **Yes** ☐ **No**
3. Have you had a change in your medical condition or had surgery? ☐ **Yes** ☐ **No**
4. Are there any changes in health since your last visit? ☐ **Yes** ☐ **No**

If yes, what changes? _____

Patient Signature _____ *Date* _____

Relationship to patient (if patient is a minor) _____

Reviewed by Dr. _____