

Medical Information

Dental History

Name of Last General Dentist

Address

City

State

Zip

Have You Requested for Your Records to be Transferred to Us?

If No, Would You Like Us to Request Your Records for You?

Date of Last Dental Visit::

Reason for this visit:

When Was Your Last Dental Cleaning?

When Were Your Last Dental X-Rays Done?

Do You Floss Your Teeth?

If Yes, How Often

What Kind of Toothbrush Do You Use:

If Electric, What Make or Model Is It?

Have You Ever Had Complications Following Dental Treatment?

If Yes, Please Describe:

Have You Been Advised To Take Antibiotics Prior To Dental Treatment?

If Yes, Reason

If Yes, What Do You Take

Have You Ever Had A Complication or A Reaction To Dental Anesthetics?

If Yes, Please Describe

Orthodontics

Have You Ever Been to An Orthodontist?

Have You Ever Had Orthodontic Treatment?

If, Yes When Did You Have Treatment?

What Type of Treatment Did You Have?

If Other type of treatment, what

Are You Under The Care of An Orthodontist Now?

Orthodontist's Name

City

State

Zip

Periodontics

Have You Ever Been To A Periodontist?

Did You Have Periodontal Treatment?

What Type of Treatment Did You Have?

Are You Under Their Care Now?

If Yes, What Type

Periodontist's Name

City

State

Zip

TMJ – Jaw Joints

Do Your Jaws (TMJ) Pop, Click or Lock?

If Yes, Which Side(s)

How Often

Do You Have Pain When you Jaws Pop, Click or Lock?

Which Side(s)?

Do you currently wear a removable acrylic appliance?

Pain

Do You Have Dental Pain or Discomfort Other Than TMJ Now?

If Yes, Please Describe

Medical History

Have you ever had any of the following? Please check those that apply:

Vascular Heart Disease

Please Describe:

Heart Attack(s)

Describe:

Heart Rythum Problems

Describe:

High Blood Pressure

Stroke

Low Blood Pressure

Heart Murmur

Anurisums

Describe:

Rheumatic Heart
Fever

Mitral Valve Prolapse

Anemia

Blood Diseases

Artificial Joints

Type(s):

AIDS

Hepatitis

Hepatitis B

Hepatitis C

Hepatitis D

Other:

Asthma

Diabetes

Type:

Dizziness

Epilepsy

Excessive Bleeding

Following Any Surgery or

Injury

Fainting

Glaucoma

Growths

Hay Fever

Head Injuries

Jaundice

Kidney Disease

Liver Disease

Mental Disorders

Nervous Disorders

Pacemaker

Pregnancy

Due date:

Radiation Treatment

Respiratory Problems

Rheumatic Fever

Rheumatism

Sinus Problems

Stomach Problems

Stroke

Tuberculosis

Mouth or Lip Ulcers

How Often Do You Get

Them:

Are You Using Anything To

Treat Them:

What Are You

Using:

Tumors

Venereal Disease

Allergies/ Bad Reactions to:

Penicillin

Erythromycin

Cephalexin (Keflex)

Clindomyacin

Asprin

NSAIDS – Non-Steroidal

Anti Inflammatory Drugs

Codine products

Other:

Please List ALL Drugs and Medications You Are Taking
(Both Prescription and Non- Prescription Drugs):

Have You Ever Been Treated For Cancer? If Yes, please
elaborate.

Have you been admitted to a hospital or needed
emergency care during the past two years? If yes, please
elaborate.

Are you now under the care of a physician? If yes, please
elaborate.

Name of Primary Physician

Phone #

Name of Secondary Physician

Phone #

When did you last visit your physician?

Why did you visit your physician?

Do you have any health problems that need further
clarification?

If yes, please explain

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any
change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian

Date: _____