It is important for us to know about your dental and medical history. Many things have a direct bearing on your dental health. I will review this questionnaire and discuss it with you in detail. Information you give me is strictly confidential and will not be released to anyone without your written permission.

Name				Date
Address	City	State	Zip	Telephone (home)
Occupation				Telephone (work)
Marital Status	Date of Birth			Social Security #
Physicians		Have family & friends been treated here?		
Previous Dentist		Referred By		
Reason for Changing				
Dental Insurance Company	Group #	Insured's Name		
Address	City	State	Zip	Insured's Social Security #

Your Current Dental Needs (Check All That Apply)

* Emergency (pain)	* Partial Dentures	* Fillings
* Routine Exam	***** Full Dentures	* Gum Treatment
* Cleaning of Teeth	* Crowns	* Root Canal
* Extractions	* Bridges	* Orthodontics

My main dental problem now is:

_____

Do you fear dental treatment?	Yes __ No__	Date of last dental cleaning_____
Have you ever been treated for periodontal disease (pyorrhea)?	Yes__ No__	How many times have you had your
Do your gums bleed?	Yes__ No__	teeth cleaned in the past 3 years? ___
Do you have difficulty chewing your food?	Yes__ No__	Are your teeth sensitive to Hot_____
Do you grind or clench your teeth?	Yes__ No__	Cold_____ Sweet____?
Do you have a bite guard/splint?	Yes__ No__	Are you satisfied with the appearance
Are spaces developing between your teeth?	Yes__ No__	of your teeth? Yes____ No____
Have you noticed your bite changing?	Yes__ No__	If no, why not?_____
Has a dentist or hygienist shown you how to clean your teeth?	Yes__ No__	Have you had gum boils or swelling?___
If yes, do you use this method of cleaning your teeth now?	Yes__ No__	How would you rate your past dental
Do you have frequent cold sores?	Yes__ No__	care? Good____ Fair____ Poor____
Have you had orthodontic treatment to straighten your teeth?	Yes__ No__	Do you desire nitrous oxide sedation
Have you ever had problems with extractions?	Yes__ No__	during treatment? Yes____ No____
Does food wedge between your teeth?	Yes__ No__	How often do you brush? _____
Has any member of your family lost all their teeth?	Yes__ No__	Do you floss? Yes__ No__ How often?__
Would you be tremendously disturbed to lose all of your teeth?	Yes__ No__	Do you use a fluoride rinse? Yes__ No__
		Is your toothbrush Soft__ Med__Hard__

DENTAL HISTORY NOTE AND UPDATES:_____

_____

_____

MEDICAL HISTORY

DO YOU HAVE OR HAVE YOU EVER HAD

Hepatitis, jaundice or liver disease	Yes__ No__ ?__	Psychotherapy or counseling	Yes__ No__ ?__
Epilepsy, convulsions or fainting spells	Yes__ No__ ?__	Alcoholism	Yes__ No__ ?__
Rheumatic fever	Yes__ No__ ?__	Other chemical addictions	Yes__ No__ ?__
Heart murmur	Yes__ No__ ?__	Any illness not listed	Yes__ No__ ?__
Heart trouble or stroke	Yes__ No__ ?__		
High or low blood pressure	Yes__ No__ ?__	**ARE PRESENTLY:**	
Shortness of breath	Yes__ No__ ?__	Under a physicians care	Yes__ No__ ?__
Chest pains	Yes__ No__ ?__	Taking any medication	Yes__ No__ ?__
Swelling in ankles	Yes__ No__ ?__	or within last year	Yes__ No__ ?__
Tuberculosis	Yes__ No__ ?__	Taking vitamins	Yes__ No__ ?__
Kidney disease or infection	Yes__ No__ ?__	Allergic to dental anesthetic	Yes__ No__ ?__
Diabetes	Yes__ No__ ?__	Aware of recent weight change	Yes__ No__ ?__
Arthritis or rheumatism	Yes__ No__ ?__	Under unusual stress	Yes__ No__ ?__
Stomach or duodenal ulcers	Yes__ No__ ?__	Under emotional tension	Yes__ No__ ?__
Medical radiation treatment	Yes__ No__ ?__	Treatment for stress	Yes__ No__ ?__
Glaucoma	Yes__ No__ ?__	Treatment for emotional tension	Yes__ No__ ?__
Asthma, hay fever or allergies	Yes__ No__ ?__	Do you bruise easily	Yes__ No__ ?__
Drug reaction to codeine/penicillin	Yes__ No__ ?__	Do you wear contact lenses	Yes__ No__ ?__
Drug reaction to tetracycline -	Yes__ No__ ?__	Do you smoke	Yes__ No__ ?__
Demerol, valium, erythromycin	Yes__ No__ ?__	If yes, how much _____	
Percocet, nitrous oxide, percodan	Yes__ No__ ?__		
Barbituates, aspirin, other	Yes__ No__ ?__	**IF FEMALE – ARE YOU NOW**	
Veneral disease	Yes__ No__ ?__	Pregnant	Yes__ No__ ?__
Surgery	Yes__ No__ ?__	Taking anti-pregnancy drug	Yes__ No__ ?__
Hospitalization for illness/surgery	Yes__ No__ ?__	Presently in menopause	Yes__ No__ ?__
Hives or skin rash	Yes__ No__ ?__	Post menopause	Yes__ No__ ?__
Cancer or abnormal growths	Yes__ No__ ?__	Menstrual cycle issues	Yes__ No__ ?__
Anemia or blood disorder	Yes__ No__ ?__		
Abnormal bleeding problems	Yes__ No__ ?__	**MAY WE REQUEST YOUR RECORDS** Yes__ No__	
AIDS, ARC, ALS	Yes__ No__ ?__		
HIV Infection	Yes__ No__ ?__		
Emphysema	Yes__ No__ ?__		
Arteriosclerosis	Yes__ No__ ?__		
Thyroid or parathyroid disease	Yes__ No__ ?__		
An artificial joint (hip, knee…)	Yes__ No__ ?__		

DENTAL/MEDICAL HISTORY NOTES:_____

_____

_____

_____

_____

_____

ANYTHING YOU WOULD LIKE TO ADD: _____

_____

_____

_____

_____

To the best of my knowledge, all of the preceding answers are true and correct. I agree to assume full financial responsibility for all treatment rendered.

_____ _____

Signature of Patient, Parent or Guardian Date