

**PERSONAL INFORMATION:**

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
 Home Address: \_\_\_\_\_ Date Of Birth: (D/M/Y) \_\_\_\_\_  
 \_\_\_\_\_  
 Postal Code: \_\_\_\_\_ Home Ph.#: \_\_\_\_\_  
 E-Mail: \_\_\_\_\_ Cell Ph. #: \_\_\_\_\_  
 Work Ph. #: \_\_\_\_\_  
 Emergency Contact: (Name/Relationship) \_\_\_\_\_  
 Phone Number(s): \_\_\_\_\_

**MEDICAL HISTORY:**

Name of Physician/and their specialty: \_\_\_\_\_

Date of last medical examination: \_\_\_\_\_ Purpose: \_\_\_\_\_

What is your estimate of your general health?:  Excellent  Good  Fair  Poor

**Do You Have or Have You Ever Had: (YES OR NO)**

	Y:	N:		Y:	N:
Glaucoma:			Osteoporosis/Osteopenia (i.e. Taking Bisphosphonates):		
Heart Problems			Alcohol / Drug Dependency:		
Heart Murmur:			Artificial Prosthesis (i.e. Heart Valve or Joints):		
Rheumatic Fever:			Tuberculosis:		
High Blood Pressure:			Breathing or Sleep Problems (i.e. Snoring, Sinus):		
Low Blood Pressure:			Liver Disease:		
HIV/AIDS:			Arthritis:		
Tumor, Abnormal Growth:			Contact Lenses:		
Radiation Therapy:			Head Or Neck Injuries:		
Chemotherapy:			Epilepsy, Convulsions (Seizures):		
Venereal Disease:			Neurologic Problems:		
Are You Taking Blood Thinners:			A Stroke:		
Hepatitis:(Type: _____)			Viral Infections and Cold Sores:		
Anti-Depressant Medication:			Any Lumps or Swelling in the Mouth:		
Anemia or Blood Disorder:			Hives, Skin Rash, Hay Fever:		
Emphysema:			Kidney Disease:		
Asthma:			Thyroid or Parathyroid Disease:		
Hormone Deficiency			Jaundice:		
Diabetes:			High Cholesterol:		
Digestive Disorders(i.e. Gastric Reflux):			Stomach or Duodenal Ulcer:		
Are You Presently Being Treated For Any Other Illness?:			(FEMALE) Are You Taking Birth Control Pills?:		
Are You Subject To Frequent Headaches?:			(FEMALE) Are you pregnant?:		
Are You A Smoker Or Smoked Previously?:					

- Are you Allergic Or Have You Ever Had An Allergic Reaction To:
- Aspirin, Ibuprofen, Acetaminophen
  - Codeine
  - Local Anesthetic
  - Fluoride
  - Metals (Titanium, Amalgam, Stainless Steel)
  - Latex
  - Penicillin
  - Erythromycin
  - Tetracycline
  - Any Other Medications

Please List Any Medications, Vitamins, Herbal or Dietary Supplements Currently Taking **AND** What It Is For:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**DENTAL HISTORY:**

What is your immediate concern?: \_\_\_\_\_

How would you rate the condition of your mouth?:  Excellent  Good  Fair  Poor

Are you fearful of dental treatment?:  YES  NO Scale of 1 (None) to 10 (Very): \_\_\_\_\_

Have you had an unfavorable dental experience?:  YES  NO

Details: \_\_\_\_\_

Have you ever had complications from past dental treatment?:  YES  NO

Details: \_\_\_\_\_

Have you ever had trouble getting numb or reactions to local anesthetic?:  YES  NO

Did you ever have braces, orthodontic treatment or had your bite adjusted?:  YES  NO

Do you / would you have any problems chewing gum?:  YES  NO

Do you / would you have any problems chewing bagels or other hard foods?:  YES  NO

Have your teeth changed in the last 5 years, become shorter, thinner or worn?:  YES  NO

Are your teeth crowding or developing spaces?:  YES  NO

Do you have any problems with sleep or wake up with an awareness of your teeth?:  YES  NO

Any problems with your jaw joint?: (Pain, Sounds, Limited Opening, Locking, Popping)  YES  NO

Do you have tension headaches or sore teeth?:  YES  NO

Do you wear or have you ever worn a bite appliance?:  YES  NO

Are any teeth sensitive to hot, cold, biting or sweets?:  YES  NO

Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth?:  YES  NO

Have you ever been diagnosed or treated for periodontal (gum) disease?:  YES  NO

Have you ever experienced gum recession?:  YES  NO

Do your gums bleed when brushing, flossing or eating?:  YES  NO

Are your teeth becoming loose?:  YES  NO

Have you ever noticed an unpleasant taste or odor in your mouth?:  YES  NO

***I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.***

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_