DENTAL EXPERTS

GENERAL HEALTH INFORMATION

DATE: _____ CHART #_____

PATIENT NAME: _____ BIRTH DATE: _____ AGE: _____
LAST FIRST

DENTAL HISTORY

1. **Reason for Visit / Main Concern**? Check-Up ❑ Cleaning ❑ Toothache ❑ Other_____
2. Are there other conditions of which we should be aware? YES ❑ NO ❑ If yes, please specify: _____
3. When did you last visit a dentist? _____ 4. What treatment was performed? _____
5. Was the treatment completed? _____ 6. When were dental x-rays taken? _____
7. Did you have a cleaning ? YES ❑ NO ❑ 8. Have you had gum (periodontal) treatment? YES ❑ NO ❑
9. Have you ever had prolonged bleeding after an extraction? YES ❑ NO ❑ If yes, please specify: _____
10. Have you had any problems with past dental treatment? YES ❑ NO ❑ If yes, please specify: _____
11. Do you grind your teeth, clinch your jaws, or have symptoms near your ears such as clicking, popping, pain or locking open? YES ❑ NO ❑ If yes, please specify: _____
12. Have you ever been diagnosed or treated for TMD (Temporomandibular Joint Dysfunction) sometimes called TMJ? YES ❑ NO ❑ If yes, please specify: _____
13. Do your gums bleed easily? YES ❑ NO ❑ 14. Do you feel you have bad breath? YES ❑ NO ❑
15. Are your teeth sensitive to hot or cold? YES ❑ NO ❑ 16. Would you like your teeth whiter? YES ❑ NO ❑
17. Are you happy with your smile? YES ❑ NO ❑ If no, please explain: _____

MEDICAL HISTORY

1. Are you under a Doctor's care at this time? YES ❑ NO ❑ If yes, please specify: _____ Dr. Name: _____
   Dr. Phone: ( ) _____
2. Are you allergic to penicillin, codeine, local anesthetics, tranquilizers or any other drugs or medicine? _____
3. Are you taking any medications at this time, including birth control? YES ❑ NO ❑ If yes, please specify: _____
4. (Women) Are you pregnant now? YES ❑ NO ❑ If yes, how many months? _____ Are you nursing? YES ❑ NO ❑
5. Are there any other health problems of which we should be advised? Please specify: _____
6. Do you have, or have you had, any of the following?

Please check "YES" or "NO"			Doctor Comments	Please check "YES" or "NO"			Doctor Comments
ARTIFICIAL HEART VALVE	YES ❑	NO ❑		HIGH BLOOD PRESSURE	YES ❑	NO ❑	
AIDS/HIV+	YES ❑	NO ❑		JAUNDICE	YES ❑	NO ❑	
ANEMIA	YES ❑	NO ❑		JOINT REPLACEMENT	YES ❑	NO ❑	
ANGINA	YES ❑	NO ❑		KIDNEY DISEASE	YES ❑	NO ❑	
ARTHRITIS	YES ❑	NO ❑		LATEX ALLERGY	YES ❑	NO ❑	
ASTHMA	YES ❑	NO ❑		LIVER PROBLEMS	YES ❑	NO ❑	
BISPHOSPHONATE THERAPY	YES ❑	NO ❑		LOW BLOOD PRESSURE	YES ❑	NO ❑	
BLEEDING PROBLEMS	YES ❑	NO ❑		LUNG DISEASE	YES ❑	NO ❑	
CANCER	YES ❑	NO ❑		PACEMAKER	YES ❑	NO ❑	
CHEMO/RAD THERAPY	YES ❑	NO ❑		PHEN-FEN/REDUX	YES ❑	NO ❑	
COSMETIC SURGERY	YES ❑	NO ❑		PSYCHIATRIC CARE	YES ❑	NO ❑	
DIABETES	YES ❑	NO ❑		RHEUMATIC FEVER	YES ❑	NO ❑	
DIZZY SPELLS/FAINTING	YES ❑	NO ❑		SINUS TROUBLE	YES ❑	NO ❑	
DRUG ADDICTION	YES ❑	NO ❑		SLEEP APNEA	YES ❑	NO ❑	
EMPHYSEMA	YES ❑	NO ❑		TOBACCO	YES ❑	NO ❑	
EPILEPSY	YES ❑	NO ❑		STROKE	YES ❑	NO ❑	
GLAUCOMA	YES ❑	NO ❑		THYROID PROBLEMS	YES ❑	NO ❑	
HEART ATTACK/SURGERY	YES ❑	NO ❑		TMD OR TMJ	YES ❑	NO ❑	
HEART MURMUR/PROBLEMS	YES ❑	NO ❑		TUBERCULOSIS	YES ❑	NO ❑	
HEPATITIS	YES ❑	NO ❑		VENEREAL DISEASE	YES ❑	NO ❑	

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. I further certify that I consent to taking x-rays and an oral examination.

Patient's signature _____ Date _____
(Parent if Patient is a Minor)

Doctor Signature _____

MEDICAL UPDATE:

1. Patient's signature _____ Doctor's Signature _____ Date _____
2. Patient's signature _____ Doctor's Signature _____ Date _____
3. Patient's signature _____ Doctor's Signature _____ Date _____