

GENERAL HEALTH INFORMATION

PATIENT NAME _____ DATE _____
DATE OF BIRTH _____

DENTAL HISTORY

1. What is the reason for your visit _____

2. When was your last dental visit? _____
3. What treatment was performed? _____
4. Was treatment completed? _____
5. When were dental x-rays taken? _____
6. Did you have a cleaning? Yes No
7. Have you had gum (periodontal) treatment? Yes No
8. Have you ever had prolonged bleeding after an extraction? Yes No If yes specify:

9. Have you ever had any problems with past dental treatments? Yes No If yes
specify _____
10. Do you grind your teeth, clench your jaws, or have symptoms near your ears such
as popping, clicking, pain, or locking? Yes No If yes specify:

11. Have you ever been diagnosed or treated for TMD (Temporomandibular Joint
Dysfunction) sometimes called TMJ? Yes No If yes specify _____
12. Do your gums bleed easily? Yes No If yes specify _____
13. Do you feel you have bad breath? Yes No If yes specify _____
14. Are your teeth sensitive to hot or cold? Yes No If yes specify _____
15. Would you like your teeth whiter? Yes No
16. Are you happy with your smile? Yes No If no specify _____

MEDICAL HISTORY

1. Are you under a Doctor's care at this time? Yes No
Dr. Name _____ Dr. Phone: _____
2. Are you allergic to penicillin, codeine, local anesthetics, tranquilizers, latex, metals
Or any other drugs or medicine? Please specify _____
3. Are you taking any medications at this time? Yes No If yes specify _____

4. Are you taking birth control? Yes No If yes specify _____
5. (Women) are you pregnant at this time? Yes No If yes, how many months _____
6. Are there any other health problems of which we should be advised? Please specify

7. Do you consume alcoholic beverages? Yes No If yes specify _____
