Date: ____________________

# PATIENT INFORMATION
**(Confidential)**

Patient Name: ______________________________________ (Last, First, MI)     Date of Birth: ______________________ (Month, Date, Year)

## DENTAL HISTORY

Reason for Today's Visit: ______________________________     Date of Last Dental Visit: ________________

Former Dentist: ______________________________     Date of Last Dental X-Rays: ________________

Contact Information for Previous Dental Office: ______________________________________________

How Often do you Brush? ________________     How Often do you Floss? ________________

Check the ☐ below if you have or have had any of the following:

| | | |
|---|---|---|
| ☐ Bad Breath | ☐ Grinding Teeth | ☐ Sensitivity to Hot |
| ☐ Bleeding Gums | ☐ Loose Teeth or Broken Fillings | ☐ Sensitivity to Sweets |
| ☐ Clicking or Popping Jaw | ☐ Periodontal Treatment | ☐ Sensitivity when Biting |
| ☐ Food Collection Between Teeth | ☐ Sensitivity to Cold | ☐ Sores and/or Growths in the Mouth |

## MEDICAL HISTORY

Physician's Name: ______________________________     Date of Last Visit: ________________

Have you had any serious illnesses or operations? ______     If yes, describe: ______________________________

______________________________________________________________________

Joint replacement? ☐ No ☐ Yes     If yes, list joint and date? ____________________     ☐ Pre-med needed?

(Women) Are you pregnant? ☐ Yes ☐ No     Nursing? ☐ Yes ☐ No     Taking birth control pills? ☐ Yes ☐ No

Check the ☐ below if you have or have had any of the following:

| | | | |
|---|---|---|---|
| ☐ Anemia | ☐ Cough, Persistent | ☐ High Blood Pressure | ☐ Shortness of Breath |
| ☐ Arthritis, Rheumatism | ☐ Cough up Blood | ☐ HIV/AIDS | ☐ Skin Rash |
| ☐ Artificial Heart Valves | ☐ Diabetes | ☐ Jaw Pain | ☐ Stroke |
| ☐ Asthma | ☐ Epilepsy | ☐ Kidney Disease | ☐ Swelling of Feet and Ankles |
| ☐ Back Problems | ☐ Fainting | ☐ Liver Disease | ☐ Thyroid Problems |
| ☐ Blood Disease | ☐ Glaucoma | ☐ Mitral Valve Prolapse | ☐ Tobacco Habit |
| ☐ Cancer | ☐ Headaches | ☐ Pacemaker | ☐ Tonsilitis |
| ☐ Chemical Dependency | ☐ Heart Murmur | ☐ Radiation Treatment | ☐ Tuberculosis |
| ☐ Chemotherapy | ☐ Heart Problems | ☐ Respiratory Disease | ☐ Ulcer |
| ☐ Circulatory Problems | ☐ Hemophilia | ☐ Rheumatic Fever | ☐ Venereal Disease |
| ☐ Cortisone Treatments | ☐ Hepatitis | ☐ Scarlet Fever | ☐ |

(Turn over to complete)

# ALLERGIES

Check the ☐ below if you are allergic to any of the following:

| | | | |
|---|---|---|---|
| ☐ Aspirin | ☐ Codeine | ☐ Penicillin | ☐ Latex |
| ☐ Barbiturates (Sleeping Pills) | ☐ Local Anesthetic | ☐ Sulfa | ☐ Other - |

**MEDICATIONS** - List any medications you are currently taking or attach a list:

______________________________________________________________________________

______________________________________________________________________________

## Sleep Health

Do you snore or been told you snore? Yes _____ No _____

Have you been diagnosed with sleep apnea? Yes _____ No_____

If so, was it recommended that you use a CPAP? Yes _____ No _____

If YES, do you use one? Yes _____ No _____

Do you clench or grind your teeth at night? Yes _____ No _____

Do you ever wake up with a headache or soreness in your facial muscles or jaw? Yes _____ No _____

Have you ever had BOTOX or Dysport? Yes _____ No _____

Have you ever had facial fillers such as Juvederm or Restylane? Yes _____ No _____

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of her staff responsible for any errors or omissions that I may have made in the completion of this form. It is my responsibility to let the staff know of any changes in my medical history each time I come to this office.

_______________________________________ Date: __________ Relationship to Patient: ______________________
Signature of patient, parent or guardian

**Reviewed and updated:**

| Date & Initials | Date & Initials | Date & Initials | Date & Initials | Date & Initials | Date & Initials | Date & Initials |
|---|---|---|---|---|---|---|
| | | | | | | |