New Patient Dental & Medical History

Patient Name: ____ Birthdate: ____________________

Emergency Contact: ____ Phone #: ________________________

Name of Primary Medical Doctor: ____

Location: ____ Date of last visit: _____________________

Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 5 years old? **Yes** ☐ **No** ☐

Do you have Bitewing x-rays that are less than 1 year old? **Yes** ☐ **No** ☐

IF YES TO ANY OF THE ABOVE:

Name of Former Dentist: ____

Dental Practice Name: ____

Date of last visit: ____

IF YOU HAVE ANSWERED "YES" TO ANY OF THE ABOVE QUESTIONS PLEASE NOTIFY THE FRONT DESK PROMPTLY SO THAT WE MAY TRANSFER YOUR RADIOGRAPHS PRIOR TO YOUR VISIT TODAY

Dental History & Symptoms

What is the reason for your visit today? ____

Are you currently experiencing any dental pain or discomfort? **Yes** ☐ **No** ☐

If yes, where? ____

Do your gums bleed when you brush or floss your teeth? **Yes** ☐ **No** ☐

Have you ever had periodontal gum treatments like scaling and root planing? **Yes** ☐ **No** ☐

Does your jaw click, pop or hurt? **Yes** ☐ **No** ☐

Have you ever had problems with dental treatment in the past? **Yes** ☐ **No** ☐

If yes, please describe what happened ____

Have you ever had a reaction to, or problem with, dental anesthesia? **Yes** ☐ **No** ☐

If yes, please describe what happened ____

Are you unhappy with your smile? **Yes** ☐ **No** ☐

If yes, please circle all that apply: **tooth color** **tooth shape** **tooth position**

other please describe: __________________________

Medical History

Do you have any history of:

	Rheumatic Fever		Thyroid Disease		Cancer
	Mitral Valve Prolapse		Blood Transfusion		Heart Murmur
	Heart Trouble		Pace Maker		Chemotherapy
	Lung Disease		Tuberculosis		Low Blood Pressure
	HIV/AIDS		Ulcers/Stomach Issues		Radiation Treatment
	Dialysis		Arthritis		Venereal Disease
	Stroke		Epilepsy or Seizures		Open Heart Surgery
	High Blood Pressure		Anemia		Diabetes
	Drug Addiction		Mouth Sores/Growths		Any type of Implant
	Hepatitis (Type: _______)		Excessive Bleeding		Breathing Problems
	Asthma		Liver Disease		Tobacco Use
	Organ transplant		Sinus problems		Anticoagulant Therapy
	Kidney Disease		Fainting or Dizziness		Artificial Joint
	Alcoholism		Psych Treatment		Teeth Grinding/Clenching

Are you allergic to any of the following? **Yes** ☐ **No** ☐

- ☐ Anesthetic
- ☐ Aspirin
- ☐ Codeine
- ☐ Ibuprofen
- ☐ Iodine
- ☐ Latex
- ☐ Penicillin
- ☐ Sulfa

Other allergies not listed above:

____

Medication	Dosage and Frequency	Condition Being Treated

IF YOU NEED MORE SPACE FOR YOUR MEDICATIONS, PLEASE REQUEST ADDITIONAL PAGES AT THE FRONT DESK

Sleep Health Questionnaire

Have you been told that you occasionally or frequently snore? **Yes** ☐ **No** ☐

Are you often tired during the day? **Yes** ☐ **No** ☐

Do you know if you ever gasp or stop breathing during sleep or has anyone observed you gasp or stop breathing while you are asleep? **Yes** ☐ **No** ☐

Have you ever had high blood pressure or are you on medication for high blood pressure?
Yes ☐ **No** ☐

Are you aware if you clench or grind your teeth while sleeping? **Yes** ☐ **No** ☐

Smile Questionnaire

1.) How important do you consider your oral health?

Not important **somewhat important** **very important**

2.) Which of the following oral health conditions have you experienced since your last dental exam? Please mark all that apply:

	Tooth ache
	Loose, chipped, cracked or broken fillings
	Grinding teeth
	Clicking or popping jaw
	Clenching jaw
	headaches
	Snoring or sleep apnea
	Sensitivity to hot, cold or sweet foods
	Red, puffy or tender gums
	Teeth have moved

3.) On a scale of 1-10, how confident are you in your smile? **1 2 3 4 5 6 7 8 9 10**

4.) If you could change your smile, would you:

	Make your teeth whiter?
	Close gaps between your teeth?
	Make your teeth straighter?
	Fix chipped or cracked teeth?
	Replace missing teeth?
	Other

5.) Have you had your teeth straightened in the past? (Braces, clear aligners or other appliances)

yes **no**