First Name: Last Name: Date:

Chart Number: Do You Need Help Filling Out This Form? ☐ YES ☐ NO

We would like to get to know you better!

Last Dental Visit: _____

We want to take care of your needs… (PLEASE ANSWER ALL QUESTION'S)

Current dental problems: ☐YES ☐NO Nervous about dental treatment: ☐YES ☐NO Dental Health: ☐Good ☐Bad

Repair Chips in teeth: ☐YES ☐NO Longer lasting solutions: ☐YES ☐NO Straighter teeth: ☐YES ☐NO

Close spaces in teeth: ☐YES ☐NO Snore or have sleep apnea:☐YES ☐NO Whiter teeth: ☐YES ☐NO

Avoid brushing part of mouth: ☐YES ☐NO Dissatisfied with teeth/appearance: ☐YES ☐NO

Interested in replacing mercury/amalgam/silver fillings ☐YES ☐NO

Sensitive to sweets, hot/cold or biting: ☐YES ☐NO

Other concerns/needs: _____

Medical History:

(PLEASE ANSWER ALL QUESTION'S)

Good Health: ☐YES ☐NO Change in general health: ☐YES ☐NO Last Physical Exam: _____

Serious illness or operation: ☐YES ☐NO what was the illness or operation: _____

Care of a physician: ☐YES ☐NO Condition being treated: _____

Blood transfusion: ☐YES ☐NO Circumstances: _____

Serious problems with previous dental work: ☐YES ☐NO Please describe problem: _____

Do you smoke or use Tobacco products: ☐YES ☐NO How much do you smoke? _____

Tumor, growth/other of the mouth or lips: ☐YES ☐NO Thirsty most of the time: ☐YES ☐NO

Has our jaw ever been stuck open or closed: ☐YES ☐NO Gums bleed when brush?☐YES ☐NO

Mouth frequently becomes dry: ☐YES ☐NO Does your jaw pop or click when opening or chewing? ☐YES ☐NO

Implants and/or prosthesis: ☐YES ☐NO

Abnormal bleeding with extractions, surgery or trauma: ☐YES ☐NO

Physician name and address: _____

Hospitalized/serious illness past five years: _____

Gender Specific Questions:

☐Female ☐Male

Pregnant or could be: ☐YES ☐NO If yes, when are you due: _____

Are you nursing? ☐YES ☐NO

Are you Currently taking oral contraceptives? ☐YES ☐NO

Do you have Porphyria (blood disorder)? ☐YES ☐NO

Specialist Specific Questions:

Have you/anyone else in your family had malignant hyperthermia/other complications while under general anesthesia? ☐YES ☐NO

Do you have habits such as nail biting, pencil biting, or lip biting? ☐YES ☐NO

Do you have habits such as thumb sucking or mouth breathing? ☐ YES ☐N

Do you clench or grind your teeth? ☐YES ☐NO

Have your wisdom teeth been extracted? ☐YES ☐NO

When were they extracted? _____

Drugs or Medications:

Are you currently taking, or have you ever taken any of the following drugs/medications? ☐YES ☐NO

☐Antibiotics or Sulfa Drugs ☐Aspirin ☐Tranquilizers ☐Anticoagulants (Blood Thinners)

☐Medication for High Blood Pressure ☐Digitalis or drugs for heart trouble ☐Nitroglycerin

☐Insulin, tolbutamide (Orinasal), or similar drugs ☐Cortisone (steroids) ☐Hormone therapy/replacement

☐Recreational or non-prescribed drugs

☐Osteoporosis, chemotherapy or multiple myeloma medications, (Bisphosphonates) such as Actonel, Boniva, Fosamax, Skidlid and Bonefos

☐Fen-Phen (now or in the past or any related drugs such as Ionimin, Adipex, Phentermine, Fastin, Pondimin (Fenfluramine), and Redux (Dexfenfluramine)

☐Other: _____

Existing Medical Conditions of The Heart: ☐YES ☐NO (If so, please select all that apply)

☐Heart Transplant ☐Rheumatic fever or rheumatic heart disease ☐Heart murmur/MVP (mitral valve prolapse)

☐Myocardial infarction ☐Low Blood Pressure ☐Heart Surgery, Bypass, Stents

☐Artificial Heart Valves ☐Congestive Heart Failure ☐Stroke

☐Cardiovascular disease (heart trouble, heart attack, coronary occlusion, arteriosclerosis)

☐Other: _____

Lungs: ☐YES ☐NO (If so, please select all that apply)

☐Emphysema ☐Hay Fever ☐Tuberculosis ☐Difficulty Breathing

☐Bronchitis ☐Chronic Cough ☐Asthma ☐Other: _____

Kidney: ☐ YES ☐NO (If so, please select all that apply)

☐Dialysis Treatment ☐Kidney Transplant ☐Frequent Urination ☐Other: _____

Liver: ☐YES ☐NO (If so, please select all that apply)

☐Hepatitis A (Infectious) ☐Hepatitis B (Serum) ☐Jaundice or Liver Disease ☐Hepatitis C

☐Other: _____

Gastrointestinal: ☐YES ☐NO (If so, please select all that apply)

☐Diverticulitis ☐Bowel Problems ☐Reflux/Heartburn GERD ☐Gastric Bypass

☐Eating Disorder ☐Ulcers ☐Other: _____

Blood/Endocrine: ☐YES ☐NO (If so, please select all that apply)

☐AIDS or HIV+ ☐Diabetes ☐Sickle Cell disease ☐Hypoglycemia ☐Thyroid

☐Sexually Transmitted Diseases ☐Anemia ☐Hemophilia

☐Other: _____

Mental Health/Nervous Disorders: ☐YES ☐NO (If so, please select all that apply)

☐Anxiety ☐Bi-Polar ☐Epilepsy/Seizures ☐Mental Health Problems ☐Depression

☐Schizophrenia ☐sleep disorder ☐Fibromyalgia ☐Autism

☐ADHD/ADD Attention Deficit ☐Other: _____

Other: ☐YES ☐NO

☐Radiation Therapy ☐Delayed Healing ☐Sinus Trouble ☐Sever headache/Migraines

☐Cancer ☐Contact Lenses ☐Chemotherapy ☐Inflammatory Rheumatism (painful, swollen joints)

☐Other: _____

Allergies: ☐YES ☐NO (If any allergies or if you reacted adversely to any of the following, please select all that apply)

☐Metal ☐Barbiturates, sedatives, or sleeping pills ☐Penicillin or other antibiotics

☐Soybean ☐Asthma or hay fever ☐Iodine ☐Local Anesthetic

☐Eggs ☐Codeine or other narcotics ☐Sulfa Drugs ☐Hives or skin rash

☐Latex ☐Aspirin ☐Oher: _____

Doctor's Notes:

Office Use: Blood Pressure _____

Patient/Parent's/ Guardian Signature:

Doctor's Signature: