



DENTAL HISTORY

Reason for Visit: _____

Are you aware of any dental problem(s)? ___ No ___ Yes*

*If yes: Duration _____ Symptoms _____

Location of problem: ___ Unknown ___ Upper right ___ Lower right ___ Lower Left ___ Upper Left

What do you feel is the present condition of your mouth? ___ Excellent ___ Good ___ Fair ___ Poor

Do your gums bleed? ___ No ___ Yes If yes, when? _____

Have you been told that you have gum disease? ___ No ___ Yes If yes when? _____)

Are your teeth acutely sensitive to ___ Hot ___ Cold ___ Sweet

Other: _____

How often do you brush your teeth? _____ How often do you floss your teeth? _____
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Name of your former dentist/practice: _____

Address: _____

Phone: _____

When was your last dental exam? _____

Was any treatment begun at your previous dental office that was not completed? ___ No ___ Yes, see below.

MEDICAL HISTORY

Has there been any change in your general health in the past year? ___ No ___ Yes

When was your last physical exam? _____ Name of Physician: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Do you have or have you had any of the following conditions? Check all that applies.

	Yes	No		Yes	No		Yes	No
A.I.D.S. or Related Complex			Diabetes			Stroke		
Arthritis			Heart Disease			Organ Transplant		
Asthma or Hay Fever			Heart Attack			Osteoporosis/Osteopenia		
Bleeding Problem			Heart Murmur			Ulcers		
Cardiovascular disease/surgery			Hepatitis			Venereal Disease		
Cancer Therapy			High Blood Pressure			Thyroid Problems		
Chemical Dependency			Liver Disease/Jaundice			Tuberculosis		
Compromised immune system			Lung/Breathing Problems			Prosthetic Implant /Joint replacement surgery		
Epilepsy/Seizures			Smoking/tobacco use			Psychiatric Care		

Are you pregnant? ___ No ___ Yes If yes, how far along are you? _____

Current Medications: _____

Please list any drug allergies and, if applicable, reactions you have had _____

Please list anything else you feel would be valuable for us to know _____

Signature (of parent/guardian if patient is a minor) Relationship Date

Please complete this form, sign and bring it along when you check-in at the Dental Clinic in Boynton Health Service.