PRESTIGE DENTISTRY

COSMETIC & GENERAL DENTISTRY

PATIENT NAME ______________________________ **DATE** ______________

Primary reason for this dental appointment: ❑ Examination ❑ Emergency ❑ Consultation

Dental History

	Please Circle	
Do you have a specific dental problem? Describe ______	Yes	No
Do you have dental examinations on a routine basis? Last visit ______	Yes	No
Do you think you have active decay or gum disease? ______	Yes	No
Do you brush and floss on a routine basis? Discuss ______	Yes	No
Do your gums ever bleed? Discuss ______	Yes	No
Do you like your smile? Why? ______	Yes	No
Does food catch between your teeth? Any loose teeth? ______	Yes	No
Do you want to keep your remaining teeth? ______	Yes	No
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? ______	Yes	No
Have your past experiences in a dental office always been positive? ______	Yes	No
Do you smoke or chew? Any sores or growths in your mouth? Discuss ______	Yes	No

Name of previous dentist (optional): ______

Date of last full mouth x-rays (16 small films or panoramic): ______

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ❍ Yes ❍ No If please explain: ______

Have you ever been hospitalized or had a major operation? ❍ Yes ❍ No If please explain: ______

Have you ever had a serious head or neck injury? ❍ Yes ❍ No If please explain: ______

Are you taking any medications, pills, or drugs? ❍ Yes ❍ No If please explain: ______

Do you take, or have you taken, Phen-Fen or Redux? ❍ Yes ❍ No ______

Are you on a special diet? ❍ Yes ❍ No ______

Do you use tobacco? ❍ Yes ❍ No

Do you use controlled substances? ❍ Yes ❍ No

Women: Are you

Pregnant/Trying to get pregnant? ❍ Yes ❍ No Taking oral contraceptives? ❍ Yes ❍ No Nursing? ❍ Yes ❍ No

Are you allergic to any of the following?

❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Acrylic ❑ Metal ❑ Latex ❑ Local Anesthetics

❑ Other If yes, please explain: ______

Do you have, or have you had, any of the following?

AIDS/HIV Positive	❍ Yes ❍ No	Cortisone Medicine	❍ Yes ❍ No	Hemophilia	❍ Yes ❍ No	Renal Dialysis	❍ Yes ❍ No
Alzheimer's Disease	❍ Yes ❍ No	Diabetes	❍ Yes ❍ No	Hepatitis A	❍ Yes ❍ No	Rheumatic Fever	❍ Yes ❍ No
Anaphylaxis	❍ Yes ❍ No	Drug Addiction	❍ Yes ❍ No	Hepatitis B or C	❍ Yes ❍ No	Rheumatism	❍ Yes ❍ No
Anemia	❍ Yes ❍ No	Easily Winded	❍ Yes ❍ No	Herpes	❍ Yes ❍ No	Scarlet Fever	❍ Yes ❍ No
Angina	❍ Yes ❍ No	Emphysema	❍ Yes ❍ No	High Blood Pressure	❍ Yes ❍ No	Shingles	❍ Yes ❍ No
Arthritis/Gout	❍ Yes ❍ No	Epilepsy or Seizures	❍ Yes ❍ No	Hives or Rash	❍ Yes ❍ No	Sickle Cell Disease	❍ Yes ❍ No
Artificial Heart Valve	❍ Yes ❍ No	Excessive Bleeding	❍ Yes ❍ No	Hypoglycemia	❍ Yes ❍ No	Sinus Trouble	❍ Yes ❍ No
Artificial Joint	❍ Yes ❍ No	Excessive Thirst	❍ Yes ❍ No	Irregular Heartbeat	❍ Yes ❍ No	Spina Bifida	❍ Yes ❍ No
Asthma	❍ Yes ❍ No	Fainting Spells/Dizziness	❍ Yes ❍ No	Kidney Problems	❍ Yes ❍ No	Stomach/Intestinal Disease	❍ Yes ❍ No
Blood Disease	❍ Yes ❍ No	Frequent Cough	❍ Yes ❍ No	Leukemia	❍ Yes ❍ No	Stroke	❍ Yes ❍ No
Blood Transfusion	❍ Yes ❍ No	Frequent Diarrhea	❍ Yes ❍ No	Liver Disease	❍ Yes ❍ No	Swelling of Limbs	❍ Yes ❍ No
Breathing Problem	❍ Yes ❍ No	Frequent Headaches	❍ Yes ❍ No	Low Blood Pressure	❍ Yes ❍ No	Thyroid Disease	❍ Yes ❍ No
Bruise Easily	❍ Yes ❍ No	Genital Herpes	❍ Yes ❍ No	Lung Disease	❍ Yes ❍ No	Tonsillitis	❍ Yes ❍ No
Cancer	❍ Yes ❍ No	Glaucoma	❍ Yes ❍ No	Mitral Valve Prolapse	❍ Yes ❍ No	Tuberculosis	❍ Yes ❍ No
Chemotherapy	❍ Yes ❍ No	Hay Fever	❍ Yes ❍ No	Pain in Jaw Joints	❍ Yes ❍ No	Tumors or Growths	❍ Yes ❍ No
Chest Pains	❍ Yes ❍ No	Heart Attack/Failure	❍ Yes ❍ No	Parathyroid Disease	❍ Yes ❍ No	Ulcers	❍ Yes ❍ No
Cold Sores/Fever Blisters	❍ Yes ❍ No	Heart Murmur	❍ Yes ❍ No	Psychiatric Care	❍ Yes ❍ No	Venereal Disease	❍ Yes ❍ No
Congenital Heart Disorder	❍ Yes ❍ No	Heart Pace Maker	❍ Yes ❍ No	Radiation Treatments	❍ Yes ❍ No	Yellow Jaundice	❍ Yes ❍ No
Convulsions	❍ Yes ❍ No	Heart Trouble/Disease	❍ Yes ❍ No	Recent Weight Loss	❍ Yes ❍ No		

Have you ever had any serious illness not listed above? ❍ Yes ❍ No If yes, please explain: ______

Comments: ______

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______ DATE ______