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Aesthetic Restorative Dentistry
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Personal, Dental & Medical History Information

Welcome to our practice! So that we may provide you with the best possible care, please complete all pages of this personal/dental/medical history form. All information is completely confidential. Thank you.

Date:_____

Name:_____ Preferred Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Home Phone Number:_____ Work Phone Number:_____

Cell Phone/Pager:_____ Email Address:_____

Preferred Method of Contact: Home Phone____ Work Phone____ Cell Phone____ Email____Text____

Date of Birth:_____ Social Security #:_____

Emergency Contact:_____ Relationship:_____

Emergency Contact's Phone Number:_____

Other Family Members:_____

Whom may we thank for referring you to our office?_____

DENTAL INSURANCE INFORMATION:

Insured's Name:_____ Social Security Number:_____

Insured's Date of Birth:_____ Group #:_____

Employer:_____ Location:_____

Insurance Company:_____ Claims Address:_____

(As a courtesy to our patients with dental insurance, we will file all claims for you.)

DENTAL HISTORY:

What is the reason for your visit today? _____
Date of your last dental visit? _____
Has a dental office taken x-rays within one year? YES NO
Name of Previous Dentist:_____
Location:_____ Phone Number: _____
May we contact this dentist for your current records? YES NO
How often do you have dental examinations performed? _____
How often do you brush your teeth? _____ How often do you floss? _____
Have you ever used or are currently using topical fluoride? YES NO
What other dental aids do you currently use?(Interplak, toothpicks, etc.) _____
Do you have any dental problems now? Explain. YES NO _____
Do you feel nervous about having dental treatment completed? YES NO What is your greatest concern?

_____
Have you ever had an upsetting dental experience? Explain. YES NO

_____

Have you ever had:

Orthodontic treatment?	YES NO
Oral surgery?	YES NO
Periodontal surgery?	YES NO
Your bite adjusted?	YES NO
A bite plate or mouth guard?	YES NO

Have you experienced:

Clicking or popping of the jaw?	YES NO
Pain (jaw joint, ear or side of face)	YES NO
Difficulty in opening or closing?	YES NO
Head, neck or shoulder aches?	YES NO
Sore muscles (neck, shoulders)?	YES NO

Are any of your teeth sensitive to: Hot or Cold? YES NO Sweets? YES NO Biting or chewing? YES NO
Do you grind or clench your teeth while awake or asleep? YES NO
Do you bite your lips or your cheeks regularly? YES NO
Do you hold foreign objects with your teeth? (pencils, pins, fingernails, etc) YES NO
Do you mouth breathe while awake or asleep? YES NO
Do you have tired jaws, especially in the morning? YES NO
Do you snore or have any other sleeping disorders? YES NO
Do your gums bleed when you floss or brush your teeth? YES NO
Have you noticed any loose teeth or change in your bite? YES NO
Have your parents experienced gum disease or tooth loss? YES NO
Does food ever get caught in your teeth? YES NO If yes, where? _____
Do you suffer from lack of saliva or chronic dry mouth? YES NO
Do you often notice a bad taste in your mouth? YES NO
Do you frequently get cold sores, blisters or any other oral lesions? YES NO
Is your breath as fresh as you would like? YES NO
Are your teeth as white as you would like them to be? YES NO
Would you like to keep all of your teeth for your lifetime? YES NO
Is there anything about your smile you would like to change? YES NO _____
Have you ever been told to take a pre-medication prior to dental treatment? YES NO _____

MEDICAL HISTORY:

1. **CIRCLE** any of the following which you have had or have at present:

Heart Failure	Emphysema	AIDS
Heart Disease or Attack	Cough	Hepatitis A (infection)
Angina Pectoris	Tuberculosis (TB)	Hepatitis B (serum)
High Blood Pressure	Asthma	Hepatitis C
Heart Murmur	Hay Fever	Yellow Jaundice
Mitral Valve Prolapse	Sinus Trouble	Blood Transfusion
Congenital Heart Lesions	Allergies or Hives	Drug Addiction
Scarlet Fever	Diabetes	Hemophilia
Artificial Heart Valve	Thyroid Disease	Venereal Disease
Heart Pacemaker	X-ray or Cobalt Treatment	Cold Sores
Heart Surgery	Chemotherapy (Cancer, Leukemia)	Genital Herpes
Artificial Joints	Arthritis	Epilepsy or Seizures
Anemia	Rheumatism	Fainting or Dizziness
Rheumatic Fever	Cortisone Medicine	Nervousness
Kidney Trouble	Glaucoma	Psychiatric Treatment
Ulcers	Pain in Jaw Joints	Sickle Cell Disease
Liver Disease	Bruise Easily	Stroke
Sjorgen's Syndrome	Chronic/Migraine Headaches	

2. Have you been a patient in the hospital during the last two years? Explain. YES NO

_____

3. Have you been under the care of a medical doctor during the past two years? Explain. YES NO

_____

4. Are you allergic to (i.e. itching, rash, swelling of hands, feet or eyes) latex, penicillin, aspirin, codeine or any drugs or medications? Explain. YES NO

_____

5. Have you ever had any excessive bleeding requiring special treatment? Explain. YES NO

_____

6. When you climb stairs or take a walk, do you ever have to stop because of pain in your chest, shortness of breath or because you are very tired? YES NO
7. Do your ankles swell during the day? YES NO
8. Do you use more than 2 pillows to sleep? YES NO
9. Have you lost or gained more than 10 pounds in the past year? YES NO
10. Do you ever wake up from sleep short of breath? YES NO
11. Do you suffer from sleep apnea or use a C-Pap machine? YES NO
12. Have you ever been told that you snore? YES NO
13. Are you on a special diet? YES NO
14. Do you use tobacco products? YES NO
15. Do you consume alcohol on a regular basis? YES NO
16. Has your medical doctor ever said you have cancer or a tumor? Explain. YES NO

_____

17. Do you have any disease, condition or problem not listed? Explain. YES NO

_____

18. Have you ever taken any bones loss prevention drugs such as Fosamax, Actonel or Boniva? YES NO
19. May we contact your physician if needed? YES NO

20. **WOMEN:**

Are you pregnant or think you could be pregnant?	YES NO
Do you anticipate becoming pregnant?	YES NO
Do you use birth control prescriptions?	YES NO
Are you nursing?	YES NO

21. Are you currently taking any PRESCRIPTION medications? YES NO
22. Are you currently taking any OVER THE COUNTER medications? YES NO
23. Are you currently taking any HERBAL/VITAMIN or MINERAL SUPPLEMENTS? YES NO

List ALL medications you currently take, including prescription, over-the-counter, herbal/vitamin or mineral supplements.

Name of Medication	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Physician's Name:_____ Phone Number:_____

Specialist:_____ Phone Number:_____

Name of Pharmacy: _____ Phone Number:_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

Date:_____ Staff Signature:_____ Patient Signature:_____

History Review:

Dentist Signature: _____ Date: _____