Signature Smile
FAMILY PRACTICE DENTISTRY

Patient Name:_____ DOB:_____ SSN:_____

Dental History

What is the reason for your dental visit today?_____
When was your last dental treatment?_____ Last Cleaning:_____ X-Rays: _____
Have you had a bad dental experience? **Yes/No** If yes, please explain._____
Have you ever had periodontal treatment (Gum Disease)? **Yes/No** Do your gums bleed? **Yes/No**
How often do you brush your teeth?_____ Floss?_____
Do you use anything else for homecare? (rinses, toothpicks)_____
Do you have any loose teeth? **Yes/No** Does food catch between your teeth? **Yes/No**
Have you noticed any lumps, growths, or swelling in your mouth? **Yes/No** Sensitivity? **Yes/No**

Medical History

Are you currently under the care of a physician? **Yes/No** If yes, please explain._____
Primary care physician's name: _____
Have you ever been hospitalized or had an operation? **Yes/No** If yes, please explain._____
Are you currently taking any medications? Please list:_____
Pharmacy name & phone number:_____
Are you allergic to any medications? Please list:_____
Are you currently taking any biophosphonates?_____

Women Only

Are you currently pregnant or trying to get pregnant? **Yes/No** Are you nursing? **Yes/No**
Are you currently taking oral contraceptives? **Yes/No**

Please check all that pertain to you

	AIDS/HIV +		Congenital Heart Disorder		Heart Murmur		Rheumatic Fever
	Allergies		Convulsions		Heart Pace Maker		Rheumatism
	Alzheimer's Disease		Cortisone Medicine		Heart Trouble/Disease		Shingles
	Anemia		Diabetes		High Blood Pressure		Shortness of Breath
	Angina/Chest Pain		Drug Addiction		Irregular Heartbeat		Sickle Cell Disease
	Arthritis/Gout		Emphysema		Kidney Problems		Sinus Trouble
	Artificial Heart Valve		Epilepsy or Seizures		Leukemia		Stomach/Intestinal Problems
	Artificial Joint		Excessive Bleeding		Liver Disease		Stroke
	Aspirin (taken daily)		Excessive Thirst		Lung Disease		Swelling of Limbs
	Asthma		Fainting Spells/Dizziness		Mitral Valve Prolapse		Thyroid Disease
	Blood Disorder		Frequent Cough		Nervousness		Tuberculosis
	Blood Transfusion		Frequent Diarrhea		Pain in Jaw		Tumors/Growths
	Breathing Problem		Frequent Headaches		Parathyroid Disease		Ulcers
	Bruise Easily		Genital Herpes		Psychiatric Care		Use of Recreational Drugs
	Cancer		Glaucoma		Radiation Treatment		Venereal Disease
	Chemotherapy		Hay Fever		Recent Weight Loss		Yellow Jaundice
	Cold Sores/Fever Blisters		Heart Attack/Failure		Renal Disease		Other

By signing below, I verify that all of the above answers are true and correct to the best of my knowledge. If any of the above information changes, I consent to notify the office in a timely manner.

Patient/Patient's Guardian Signature:_____ Date:_____

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