NAME | ADDRESS | TOWN | ZIP | PHONE HOME / BUS. | SS # PERSON RESPONSIBLE FOR PAYMENT

PLACE OF EMPLOYMENT | BIRTHDATE | AGE | SEX: M F | SOCIAL SECURITY NO. | PHYSICIAN

PARENT OR GUARDIAN | ADDRESS | TOWN | ZIP | PHONE HOME / BUS. | PREVIOUS DENTIST

PERSON TO NOFIFY IN CASE OF EMERGENCY | PHONE | REFERRED BY | DENTAL INSURANCE? YES NO | CARRIER | GROUP #

IF PATIENT IS A MINOR, PROVIDE FOLLOWING INFORMATION

MOTHER'S NAME _____

WORK PLACE _____

WORK PHONE _____ SS # _____

ADDRESS IF DIFFERENT FROM CHILD _____

FATHER'S NAME _____

WORK PLACE _____

WORK PHONE _____ SS # _____

ADDRESS IF DIFFERENT FROM CHILD _____

1. Do you think that your teeth are affecting your general health in any way? Y N
2. Are you dissatisfied with the appearance of your teeth? Y N
3. Are you worried about receiving dental treatment? Y N
4. Have you ever experienced an unusual reaction to a dental anesthetic? Y N
5. Do you have difficulty in chewing your food? Y N
6. Do you have any sensitive teeth? Y N
7. Have you ever experienced growths or sore spots in your mouth? Y N
8. Do you have difficulty in opening your mouth wide? Y N
9. Have you ever had any injury to your face or jaws? Y N
10. Do you have sinus trouble? Y N
11. Any difficult extractions in the past? Y N
12. Have you had any problems with previous dental treatment? Y N
13. Have you ever had gum disease (pyorrhea, trenchmouth)? Y N
14. Do you have bleeding gums? Y N
15. Do you drink fluoridated water? Y N
16. Do you clench or grind your teeth? Y N
17. Is your diet well-balanced? Y N
18. Do you take vitamins/supplements? Y N
19. Have you ever had or been exposed to AIDS? Y N
20. Have you ever had any of the following?
    a. Heart murmur Y N
    b. Rheumatic fever Y N
    c. Hepatitis and/or jaundice Y N
    d. Liver disease Y N
    e. Tuberculosis Y N
    f. Venereal disease Y N
    g. Heart ailment Y N
    h. Stroke Y N
    i. Stomach or intestinal diseases (i.e. Ulcers, etc.) Y N
    j. Epilepsy or convulsions Y N
    k. Diabetes Y N
    l. High blood pressure Y N
    m. Infectious Mononucleosis Y N
    n. Respiratory or lung disease Y N
    o. Hyper or Hypothyroidism Y N
    p. Blood disease (i.e. anemia, etc.) Y N
    q. Kidney disease Y N
    r. Rheumatism or arthritis Y N
21. Are you being treated by a physician for any condition at the present time? Y N
22. Are you taking any medicines now? Y N
23. Please note any medical condition not otherwise listed: _____
24. Have you ever had surgery or X-ray therapy for a tumor or cancer? Y N
25. Are you frequently ill? Y N
26. Do you often feel exhausted or fatigued? Y N
27. Do you ever have asthma, hay fever or other allergies? Y N
28. Have you ever experienced an unusual reaction to any drug (i.e. penicillin, sulfa, codeine, aspirin, etc.)? Y N
29. Do you bleed for a long time when you cut yourself? Y N
30. Do you have frequent headaches? Y N
31. Do you ever have pain in or around your ears? Y N
32. Do you have frequent colds or sore throats? Y N
33. Do you have back or neck aches? Y N
34. Do your jaw joints ever make noises? Y N
35. Has your jaw ever locked? Y N
36. Do you ever have jaw joint pain? Y N
37. Are you a mouth breather? Y N
38. Do you ever have any chest pain or shortness of breath on mild exertion? Y N
39. Do your ankles swell? Y N
40. Do you have a persistent cough or do you ever cough blood? Y N
41. Do you have any difficulty swallowing? Y N
42. Have you ever had painful or swollen joints? Y N
43. Do you have a tendency to faint? Y N
44. Are you excessively nervous? Y N
45. Females only—Are you pregnant? Y N
46. Do you smoke or use tobacco or snuff? Y N
47. What devices do you use to maintain oral hygiene? _____
48. Approximate date of last full mouth x-rays? _____
49. Approximate date you last had your teeth cleaned? _____
50. Approximate date of last physical exam? _____

_____
SIGNATURE DATE

Review Health History

Signature Date

Signature Date