PERSONAL AND DENTAL HISTORY

First Name_____ **Last Name**_____

Emergency Contact:
Name_____ Telephone_____ Relation_____

Personal History
Do you use or have you ever used:
Tobacco_____ Alcohol _____ Recreational Drugs_____
If yes, frequency and duration:_____

Oral Hygiene Practices (frequency and type)
Frequency of Brushing_____ Type of Toothpaste (fluoride containing)_____
Frequency of Flossing_____ Mouth Rinse_____
Frequency of Cleaning_____ Frequency of Dental Check-up_____
Frequency of Snack (sugar containing)_____ Others (note)_____

Dental Treatment History (please circle all applied)
Fillings_____ Crowns_____ Extractions_____ Dentures_____
Root canal(s)____ Braces_____ Implants_____ Deep Cleaning_____
Gum Surgery____ Splint (night guard)_____ Bleaching_____
Others (note)_____

Dental Concerns (reason for visit, please circle all applied)
Tooth Pain_____ Bleeding Gums_____ Cavities(decay)_____ Missing Teeth_____
Teeth Loss_____ Teeth Extraction_____ Cleaning/Exam____Jaw Joint Noise/Pain_____
Need fillings____Need Crowns(caps)___ Cosmetic (whitening)____Others (notes)_____
Are you anxious to any dental treatment (dental fear)? **YES** **NO**
Number of months since last visit:_____
What procedure was done?_____
When was last cleaning?_____
When was last x-ray?_____
Previous dentist's name, phone number and practice address (if applied):

_____
_____
_____
_____
_____

MEDICAL HISTORY

First Name_____ **Last Name**_____
Date of Birth_____ **Gender**_____ **Occupation**_____
Home Address_____
Telephone: Home_____ **Work**_____ **Cell**_____
Email:_____
Name, telephone and clinic of physician (medical doctor):

_____

Have you had or have you ever experienced any of following condition? Please circle **"YES"** or **"NO"** to **ALL** questions.

A Heart Condition	**YES NO**	**I** Diabetes	**YES NO**
B Heart Surgery	**YES NO**	**J** Tuberculosis	**YES NO**
C Valve Replacement	**YES NO**	**K** Kidney/renal Disease	**YES NO**
D Stroke	**YES NO**	**L** Hepatitis/Jaundice	**YES NO**
E High Blood Pressure	**YES NO**	**M** HIV Positive	**YES NO**
F Bleeding Disorder	**YES NO**	**N** Epilepsy/Seizures	**YES NO**
G Asthma/Lung/Respiratory	**YES NO**	**O** Joint replacement	**YES NO**
H Ulcer/Colitis	**YES NO**	**P** Cancer/Tumor	**YES NO**

Answer the following questions as completely and accurately as possible:

1. Are you taking any medication, pills or drugs (prescribed or not)? **YES NO**
If yes, please list:_____
2. Do you have a sensitive or allergy to latex? **YES NO**
3. Are you allergy to any medication or other things (nickel)? **YES NO**
If yes, please list:_____
4. Have ever received any bisphosphonates (e.g. Zometa, Aredia, Fasamox)? **YES NO**
If yes, please list:_____
5. Have you been under physician's care in the past six month? **YES NO**
If yes, for what condition(s):_____
6. Do you have any disease or condition not listed above? **YES NO**
If yes, please list:_____
7. Woman only: Are you pregnant? **YES NO**
If yes, expected due date:_____

Patient's Signature:_____ **Date:**_____

_____

Office use only

Dentist's Notes:_____
_____
_____

Blood Pressure: _____ Pulse:_____ Temperature: (if needed) _____