

DENTAL CLINIC ADMISSION RECORD, Page 1

Patient Name: _____ DOB: _____

Welcome! So that we may provide you with the best possible care please complete both sides of this dental history form. All information is completely confidential.

What is the reason for your visit today? _____

Date of Last Dental Visit: _____ Last Dental Cleaning: _____

What was done at your last dental visit? _____

Previous Dentist's Name: _____ Phone: _____

Address: _____ State: _____ Zip: _____

How often do you have dental exams? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (Interplak, toothpick, etc) _____

Do you have any dental problems now? No Yes If "yes" please describe: _____

Are any of your teeth sensitive to:

Hot or Cold? No Yes

Sweets? No Yes

Biting or Chewing? No Yes

Have you noticed any mouth odors or bad tastes? No Yes

Do you frequently get cold sores, blisters or any other oral lesions? No Yes

Do your gums bleed or hurt? No Yes

Have your parents experienced gum disease or tooth loss? No Yes

Have your noticed any loose teeth or change in your bite? No Yes

Does food tend to become caught between your teeth? No Yes

If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep? No Yes

Bite your lips or cheeks regularly? No Yes

Hold foreign objects with your teeth – pencil, pipe, pins, nails, fingernails? No Yes

Mouth breathe (awake or asleep)? No Yes

Have tired jaws in the morning? No Yes

Smoke or chew tobacco? No Yes

Have you ever had:

Orthodontic treatment? No Yes

Oral surgery? No Yes

Periodontal treatment? No Yes

Have you ever had:

Your teeth ground or the bite adjusted? No Yes

A bite plate or mouth guard? No Yes

A serious injury to the mouth or head? No Yes

If yes, please describe: _____

Have you experienced:

Clicking or popping of the jaw? No Yes

Pain in the joint, ear, side of face? No Yes

Trouble opening or closing mouth? No Yes

Trouble chewing on either side? No Yes

Head, neck or shoulder aches? No Yes

Sore muscles in head, neck, shoulder? No Yes

Are you satisfied with your teeth's appearance? No Yes

Would you like to keep all of your teeth all of your life? No Yes

Are you nervous about dental treatment? No Yes

If so, what is your biggest concern? _____

Anything else you would like us to know?

DENTAL CLINIC ADMISSION RECORD, Page 2

1. Have you been under the care of a medical doctor during the past two years? Yes No
 If yes, for what? _____
 Physician's Name _____ Phone _____
 Address _____
2. Have you taken any medications or drugs during the past two years?..... Yes No
3. Are you taking any medications, drugs or pills now?..... Yes No
 If yes, please list name and dosage _____
4. Are you aware of having an allergic or adverse reaction to any medication or substance?..... Yes No
 If yes, please list _____
5. Have you been a patient in a hospital in the past five years?..... Yes No
6. Indicate which of the following you have had or have at present. Circle "Yes" or "No" to each item

Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Hepatitis A (Infectious) B (Serum)	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	HIV Positive	Yes	No
High Blood Pressure	Yes	No	Contact Lenses	Yes	No	Cold Sores/ Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Blood Transfusion	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Hemophilia	Yes	No
Heart Pace maker	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Bruise easily	Yes	No
Arthritis/Rheumatism	Yes	No	Hay fever	Yes	No	Liver Disease	Yes	No
Cortisone Medicine	Yes	No	Latex Sensitivity	Yes	No	Yellow Jaundice	Yes	No
Swollen Ankles	Yes	No	Allergies or Hives	Yes	No	Neurological Disorders	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Artificial Joints	Yes	No	Chemotherapy	Yes	No	Nervous/Anxious	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Psychiatric/Psychological Care	Yes	No

7. Do you use more than two pillows to sleep?..... Yes No
8. Have you lost or gained more than 10 pounds in the past year?..... Yes No
9. Do you have or have you had any disease, condition, or problem not listed?..... Yes No
10. Women: Are you pregnant? Yes No Nursing? Yes No Taking Birth Control Pills? Yes No

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 medications.

Patient/Guardian Signature: _____ Date: _____

History Review

Provider Signature _____ Date: _____