Accurate Family DENTAL
Come in for a Great Smile

**PATIENT NAME** _____ DATE _____

## Dental History

How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

**Please Circle**

Do you have a specific dental problem? Please Describe. _____ Yes No

Are any of your teeth sensitive to heat, cold or bite pressure. _____ Yes No

Do you think you have active decay or gum disease? ☐Yes ☐No Do your gums ever bleed? Discuss: _____ Yes No

Do you brush and floss on a routine basis? Discuss: _____ Yes No

Does food catch between your teeth? ☐Yes ☐No Any loose teeth? ☐Yes ☐No Do you want to keep your remaining teeth? _____ Yes No

- Do you ever have clicking, popping, discomfort or pain in the jaw joint? ☐Yes ☐No Do you brux or grind? _____ Yes No

Do you chew ice, bite your nails? ☐Yes ☐No Do you suffer from dry mouth? _____ Yes No

Has your past experience in a dental office always been positive? _____ Yes No

Any sores or growth in your mouth? Discuss _____ Yes No

- Do you smoke or chew tobacco? ☐Yes ☐No Frequency: _____ Duration: _____ High sugar/soda intake? _____ Yes No

Do you drink Alcohol beverages? ☐Yes ☐No If yes (Please Circle) Light Moderate Heavy

Do you or have you used illicit drugs? What? _____ Yes No

What would you like to change about your smile? (Please Circle) Whiter Teeth Straighter Teeth Fix Gaps And Broken Teeth

## Medical History

Are you under a physicians care now? ☐Yes ☐No Why? _____ Physicians Name: _____ Phone: _____

Have you ever been hospitalized or had a major operation? Discuss: _____ Yes No

Have you ever had a serious injury to your head or neck? Discuss: _____ Yes No

Are you taking medications, vitamins, herbal pills or drugs? ☐Yes ☐No If yes, please list the names. _____

- Are you allergic to any medications or substances? ☐Yes ☐No If Yes, Check all that apply.

☐ Local Anesthetics/Novocain ☐ Penicillin ☐ Ibuprofen ☐ Codeine ☐ Metal ☐ Latex/Rubber ☐ Antibiotics ☐ Other _____

- Do you take Blood thinners? ☐Yes ☐No If Yes, Check all that apply.

☐ Aspirin ☐ Coumadin/Warfarin ☐ Plavix ☐ Eliquis ☐ Pradaxa ☐ Xeralto ☐ Other _____

- Women (Please check): ☐ Pregnant/trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives ☐ Taking Bisphosphonates
- Are you aware that an antibiotic may interfere with the function of birth control pills _____ Yes No

Do you now have or have you ever had any of the following? Do you take any of these medicines? Please check appropriate boxes.

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Heart Disease/Surgery | Yes No | Bacterial Endocarditis | Yes No | Tuberculosis | Yes No | Tattoos | Yes No | Fever/Blisters/Cold Sore | Yes No |
| Heart Murmur or Defect | Yes No | Excessive Bleeding | Yes No | Tumors or Growth | Yes No | Excessive thirst | Yes No | Herpes | Yes No |
| Heart Attack/Failure/MI | Yes No | Sickle Cell Disease | Yes No | Cancer | Yes No | Hypoglycemia | Yes No | Drug Addiction/Alcoholism | Yes No |
| Angina/Chest Pain | Yes No | Hemophilia | Yes No | Chemotherapy/Radiation | Yes No | Liver Disease | Yes No | Convulsions/Vertigo | Yes No |
| Congenital Heart Disorder | Yes No | Methemoglobinemia | Yes No | Hypercalcemia | Yes No | Hepatitis A (Infectious) | Yes No | Epilepsy or Seizures | Yes No |
| Mitral Valve Prolapse | Yes No | Leukemia | Yes No | Osteoporosis | Yes No | Hepatitis B or C | Yes No | Fainting or Dizziness | Yes No |
| Artificial Heart Valve | Yes No | High Cholesterol | Yes No | Inj Prolia, Inj Xgeva | Yes No | Kidney Problems | Yes No | Glaucoma | Yes No |
| Heart Pace Maker | Yes No | Lung Disease / COPD | Yes No | Aredia I.V. Reciast I.V. Zometa I.V. | Yes No | Renal Dialysis | Yes No | Nervousness/Anxiety | Yes No |
| High Blood Pressure | Yes No | Breathing Problems/Asthma | Yes No | Fosamax, Actionel, Boniva | Yes No | Thyroid Disease | Yes No | Psychiatric Care | Yes No |
| Low blood Pressure | Yes No | Frequent Cough | Yes No | Ulcers / Acid Reflux | Yes No | Parathyroid Disease | Yes No | Alzheimer's Disease | Yes No |
| Scarlet Fever | Yes No | Sinus Trouble | Yes No | Stomach/Intestinal Disease | Yes No | Arthritis/Gout | Yes No | Allergies (Pollen/Dust) | Yes No |
| Rheumatic Fever | Yes No | Emphysema | Yes No | Recent Weight Loss | Yes No | Rheumatism | Yes No | Hives or Rash | Yes No |
| Bruise Easily/Blood Disease | Yes No | STDs | Yes No | Diabetes Type I / II | Yes No | Cortisone medicine | Yes No | Need Premedication | Yes No |
| Stroke | Yes No | AIDS/HIV positive | Yes No | Anemia | Yes No | Artificial Joints | Yes No | Ever taken fen-phen? | Yes No |

Have you ever had any illness or taking medications not checked above? Discuss: _____ Yes No

Do you wish to talk to the dentist privately about any problems? _____ Yes No

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or my medications, I shall inform the dentist and staff at the appointment without fail.

X _____ Date: _____

PATIENT SIGNATURE (PARENT OR GUARDIAN)

Reviewed By Doctor: _____ Date: _____ BP: _____ Pulse: _____

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