Patient Last Name:_____Patient First Name:_____

Reason for today's visit: _____

Former Dentist:_____Date of last Dental Exam_____Date of last X-rays_____

Please circle if you have/had:

Bad Breath	YES/NO	Head, neck or jaw pain	YES/NO
Blisters on lips or mouth	YES/NO	Lip or cheek biting	YES/NO
Burning sensation on tongue	YES/NO	Loose/Broken teeth	YES/NO
Chew on one side of mouth	YES/NO	Mouth breathing	YES/NO
Cigarette or Pipe Smoke	YES/NO	Orthodontic Treatment	YES/NO
Smokeless Tobacco	YES/NO	Nitrous Oxide	YES/NO
Dry Mouth	YES/NO	Periodontal Treatment	YES/NO
Food Collection	YES/NO	Sensitivity	YES/NO
Clench or grind teeth	YES/NO		
Growth or Sores in Mouth	YES/NO		
Gums swollen, tender or bleeding	YES/NO		

How often do you floss?_____ How often do you brush?_____
Have you ever had an allergic reaction to Novocaine, local or general anesthetics? YES/NO
If YES please explain:_____
Have you ever had trouble from previous dental care?_____
Physicians Name/Number:_____Date of last visit_____
Have you ever had a serious illness or operations YES/NO
If YES please Explain_____
Have you ever had a blood transfusion YES/NO Explain_____
(Women) are you pregnant? YES/NO

Please Circle if you have/had:

Anemia	YES/NO	Heart Murmur	YES/NO
Artificial Heart Valve	YES/NO	Heart Problems	YES/NO
Artificial Joints	YES/NO	Hepatitis	YES/NO
Asthma	YES/NO	High BP	YES/NO
Bleeding abnormally	YES/NO	Immune Deficiency	YES/NO
Cancer	YES/NO	Low BP	YES/NO
Chemical Dependency	YES/NO	Mitral Valve Prolapse	YES/NO
Chemotherapy	YES/NO	Pacemaker	YES/NO
Circulatory Problems	YES/NO	Respiratory Disease	YES/NO
Diabetes	YES/NO	Shortness of Breath	YES/NO
Emphysema	YES/NO	Stroke	YES/NO
Epilepsy	YES/NO	Venereal Disease	YES/NO
Fainting	YES/NO	Currently under the care of Physician?	YES/NO
Glaucoma	YES/NO	Are you allergic/sensitive to latex?	YES/NO

Allergic to Penicillin, Aspirin, or other drugs? YES/NO Please List _____
List any medications that you are taking_____

I have read and answered the above questions to the best of my knowledge.

Signature:_____ Date:_____