Blue Coast DENTAL GROUP

Patient Name: _____

Practice Name Here

DENTAL HEALTH HISTORY

Reason for today's visit: ☐ Exam ☐Emergency ☐ Consultation Are you in pain: ☐ Yes ☐ No For how long:_____

Do you require pre-medication: ☐ Yes ☐ No ☐ Don't know Previous Dentist: _____
Name Tel #

Date of Last Dental Exam: _____ Date of last X-rays :_____ Do you have copies ☐Yes ☐No

Times a Day you Brush: _____ Times a week you Floss: _____ How would you rate your smile? 1 2 3 4 5 6 7 8 9 10 (best)

Have you ever had complications after dental care: ☐ Yes ☐ No If yes, please explain: _____

In the dental office have you ever had Nitrous Sedation? ☐ Yes ☐ NO, Oral sedation? ☐ Yes ☐ No, General Anesthesia? ☐ Yes ☐ No

Is there a specific area of dental treatment you believe you need? ☐ Yes ☐ No Explain: _____

Would you like to discuss options to improve your smile? ☐ Yes ☐ No _____

Have you ever had your teeth whitened? ☐ Yes ☐ No If yes, what method(s)? _____

Do you have any Dental Implants? ☐ Yes ☐ No

Please indicate any of the following problems by checking off the corresponding box

☐Discomfort, clicking or popping in the jaw
☐Red swollen or bleeding gums
☐Sensitive tooth, teeth or gums
☐Blisters/sores around the mouth
☐Lost /Broken Filling(s)
☐Teeth grinding/clenching
☐Ringing in ears
☐Broken/chipped teeth
☐Stained Teeth
☐Locking jaw
☐Bad Breath
☐Burning tongue
☐Difficulty closing jaw
☐Swelling/lumps in mouth
☐Loose/shifting teeth
☐Food caught between teeth

☐My teeth are sensitive to: ☐Hot ☐Cold ☐Sweets ☐Biting ☐Other: _____

☐TMJ/TMD, If so do you wear a mouth guard/night guard? _____

Have you ever had your teeth equilibrated/adjusted? ☐ Yes ☐ No

Do you have Dental Anxiety or fear of treatment? ☐ Yes ☐ No If yes, how have you handled it in the past: _____

MEDICAL HEALTH HISTORY

Are you in good health: ☐ Yes ☐ No Primary Care Physician: _____ Dr. Tel. #_____

Have you had any illness, operation, or been hospitalized in the past 5 years: ☐ Yes ☐ No If Yes, explain: _____

Are you taking any of the following medications:
☐ Muscle relaxers ☐ Nerve Pills ☐ Pain Killers (including aspirin) ☐ Stimulants ☐ Blood Thinners
☐ Tranquilizers ☐ Insulin/Diabetes Meds
☐ Herbal supplements If so, list purpose _____

☐Other (please list and state purpose) _____

_____

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Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N		Y N		Y N		Y N	
☐☐	Heart Attack / Stroke	☐☐	Thyroid Problems	☐☐	Cancer / Tumors	☐☐	Cosmetic Surgery
☐☐	Heart Surgery / Pacemaker	☐☐	Kidney Problems	☐☐	Shingles	☐☐	X-Ray / Cobalt Treatment
☐☐	Angina	☐☐	Rheumatic Fever	☐☐	Tuberculosis	☐☐	Diabetes / Hypoglycemia
☐☐	Internal Defibrillator	☐☐	Respiratory Problems	☐☐	Nervousness	☐☐	Leukemia
☐☐	Heart Stint	☐☐	Scarlet Fever	☐☐	Hepatitis	☐☐	High / Low Blood Pressure
☐☐	Heart Murmur	☐☐	Liver Problems	☐☐	Chemotherapy	☐☐	Bleeding Problems
☐☐	HIV / AIDS / ARC	☐☐	Asthma	☐☐	Arthritis / Rheumatism	☐☐	Anemia
☐☐	Mitral Valve Prolapse	☐☐	Sinus Problems	☐☐	Difficulty Breathing	☐☐	Glaucoma
☐☐	Artificial Valves	☐☐	Stomach Problems	☐☐	Emphysema	☐☐	Artificial Bones / Joints
☐☐	Heart Disease	☐☐	Psychiatric Problems	☐☐	Fainting / Seizures / Epilepsy	☐☐	Eating Disorder / Anorexia / Bulimia
☐☐	Congenital Heart Defect	☐☐	Venereal Disease	☐☐	Severe / Frequent Headaches	☐☐	Back Problems
☐☐	Chest Pains	☐☐	Alcohol / Drug Abuse	☐☐	Frequent Neck Pain		

Please list any other medical conditions you have or ever had: _____

_____

Are you allergic to the following:

☐ **Latex** ☐ **Penicillin/Amoxicillin** ☐ **Tetracycline** ☐ **Aspirin** ☐ **Sulfites** ☐ **Sulfa Drugs**
☐ **Dental Anesthetics** ☐ **Others:**_____

Do you use tobacco? ☐ Yes ☐ No / If yes how much and how long? _____

Please rate your general health from 1-10 (10 = excellent)? 1 2 3 4 5 6 7 8 9 10 (best)

Have you ever taken the Phen-fen or Redux? ☐ Yes ☐ No Do you wear contact lenses? ☐ Yes ☐ No

For Women: Are you taking Birth Control Pills? ☐ Yes ☐ No Are you Pregnant: ☐Yes ☐ No If so, Due Date: _____

How many children have you had? _____ Are you nursing? _____

To the best of my knowledge all of the preceding answers and information provided are and true and correct. If I ever have any change in my health, I will inform the dental office at the next appointment without fail.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims and consult with referring doctors in compliance with HIPPA standards.

_____ _____/____/_____
Signature ☐Patient ☐Guardian Date

Office Use Only
Notes: _____

_____