

Welcome to Smile Loft Branch Ave!

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

Patient Name _____	Medical Alert _____
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What is the reason for your visit today? _____

Date of Last Dental Visit _____ **Last Dental Cleaning** _____ **Last Full Mouth X-rays** _____

What was done at your last dental visit? _____

Previous Dentist's Name _____

Address _____

Telephone _____

How often do you have dental examinations? _____

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? Yes No

If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad taste?	Yes	No
Do you frequently get cold sores, blisters, or other oral lesions?	Yes	No

Do your gums bleed or hurt? Yes No

Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught between your teeth?	Yes	No
If yes, where? _____		

Do you:

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth (pencils, pipe, pins, nails, fingernails)?	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke/chew tobacco?	Yes	No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No
If so, please describe, including cause _____		

Have you experience:

Clicking or popping of the jaw?	Yes	No
Pain (joint, ear, side of face)?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles (neck shoulders)?	Yes	No

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

Would you like to keep all of your teeth all of your life?	Yes	No
Do you feel nervous about having dental treatment? If yes, what is your biggest concern? _____	Yes	No

Have you ever had an upsetting dental experience? Yes No
If yes, please describe _____

Is there anything else about having dental treatment that you would like us to know? Yes No

If yes, please describe _____

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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 _____ City _____ State _____ Zip _____
2. Have you taken any medication or drugs the past two years?Yes N
3. Are you taking any medication, drug 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 the hospital during that past five years?.....Yes No
6. Indicate which of the following you have ad, 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	GlaucomaYes...No	H.I.V. PositiveYes...No
High Blood PressureYes...No	Contact lensesYes...No	Cold Sores/Fever BlistersYes...No
Mitral Valve ProlapseYes...No	EmphysemaYes...No	Blood TransfusionYes...No
Artificial Heart ValveYes...No	Chronic CoughYes...No	HemophiliaYes...No
Heart PacemakerYes...No	TuberculosisYes...No	Sickle Cell DiseaseYes...No
Rheumatic FeverYes...No	AsthmaYes...No	Bruise EasilyYes...No
Arthritis/RheumatismYes...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
StrokeYes...No	Sinus Trouble.....Yes...No	Epilepsy or Seizures.....Yes...No
Diet (Special/Restricted).....Yes...No	Radiation TherapyYes...No	Fainting or Dizzy SpellsYes...No
Artificial Joints (hip, knee, etc.).....Yes...No	ChemotherapyYes...No	Nervous/AnxiousYes...No
Kidney Trouble.....Yes...No	Tumors.....Yes...No	Psychiatric/Psychological CareYes...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
If yes, please list: _____
10. **Women** Are you: **Pregnant?** Yes, _____Months 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 change in my health or medication.

11. Patient/Guardian Signature _____ Date _____