Do you have any allergies or ever had any adverse reactions to any medications? ☐ Yes ☐ No

If yes, what?____

Have you ever responded adversely to medical or dental treatment? ☐ Yes ☐ No

Are you taking any medication at this time? ☐ Yes ☐ No If yes, for what? ________________

Are you under the care of a physician? ☐Yes ☐ No If yes, for what? ____________________

If patient is a child, what is her/his weight? _______________

Women: Do you suspect you are pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Is there any information we should know about your medical history?

____

DENTAL HISTORY
(Check all that apply)

☐ Do your gums bleed?
☐ Are your teeth sensitive to hot/ cold foods or liquids?
☐ Are your teeth sensitive to sweet/ sour foods or liquids?
☐ Do you feel pain on any of your teeth?
☐ Do you have any sores or lumps in or near your mouth?
☐ Have you had any neck, back or jaw injuries?
☐ Have you ever experienced the following problems in your jaw:
  ☐ Clicking
  ☐ Pain (joint, ear, side of face)
  ☐ Difficulty in opening/ closing mouth
  ☐ Difficulty in chewing
☐ Do you have frequent headaches?
☐ Do you clench or grind your teeth?
☐ Do you bite or chew your lips/ cheeks?
☐ Have you had difficult extractions?
☐ Have you had orthodontic work?
☐ Have you had prolonged bleeding after extractions?
☐ Have you received instructions for correct brushing of teeth?
☐ Have you received instructions for correct care of gums?

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing if insurance for benefits for which I'm entitled/ I will not hold my dentist nor any member of his/ her staff responsible for any errors that I may have made in the completion of this form.

Date: ____________________ Signature: ____