

## Dental History

Have you ever had any complications following dental treatment?  Yes  No

If yes, please explain \_\_\_\_\_  
(prolonged bleeding, numbness, etc)

Do your gums bleed while brushing?  Yes  No

Do you feel pain in any of your teeth?  Yes  No

Do you feel any clicking or pain in your jaw or difficulty opening or closing?  Yes  No

Do you use tobacco products?  Yes  No

Date of last dental visit? \_\_\_\_\_ Reason for visit \_\_\_\_\_

Are you interested in straightening your teeth  Yes  No we are INVISALIGN providers.

If you could change anything about your teeth, what would it be? \_\_\_\_\_

## Health Information

Check ( x ) if you have or have had any of the following:

- |  |   |
|--|---|
| <input type="checkbox"/> AIDS (HIV)                          | <input type="checkbox"/> LATEX ALLERGY                      |
| <input type="checkbox"/> Anemia                              | <input type="checkbox"/> LIVER DISEASE                      |
| <input type="checkbox"/> Arthritis                           | <input type="checkbox"/> Mental Disorders                   |
| <input type="checkbox"/> Artificial Joint/ Joint Replacement | <input type="checkbox"/> Nervous Disorders                  |
| <input type="checkbox"/> Asthma                              | <input type="checkbox"/> PACEMAKER                          |
| <input type="checkbox"/> Blood Disease                       | <input type="checkbox"/> PREGNANCY (CURRENT) due date _____ |
| <input type="checkbox"/> BLOOD THINNER                       | <input type="checkbox"/> Radiation Therapy                  |
| <input type="checkbox"/> Cancer                              | <input type="checkbox"/> Respiratory Problems               |
| <input type="checkbox"/> Diabetes                            | <input type="checkbox"/> RHEUMATIC FEVER                    |
| <input type="checkbox"/> Dizziness                           | <input type="checkbox"/> Sinus Problems / Hay Fever         |
| <input type="checkbox"/> Eating Disorders                    | <input type="checkbox"/> Stomach Problems                   |
| <input type="checkbox"/> Epilepsy                            | <input type="checkbox"/> STROKE                             |
| <input type="checkbox"/> Excessive Bleeding                  | <input type="checkbox"/> Tuberculosis                       |
| <input type="checkbox"/> Fainting                            | <input type="checkbox"/> Tumors                             |
| <input type="checkbox"/> Glaucoma                            | <input type="checkbox"/> Ulcers                             |
| <input type="checkbox"/> Head Injuries                       | <input type="checkbox"/> Venereal Diseases                  |
| <input type="checkbox"/> HEART DISEASE                       | <input type="checkbox"/> CODEINE ALLERGY                    |
| <input type="checkbox"/> HEART MURMUR                        | <input type="checkbox"/> PENICILLIN ALLERGY                 |
| <input type="checkbox"/> HEPATITIS                           | <input type="checkbox"/> SULFA ALLERGY                      |
| <input type="checkbox"/> HIGH BLOOD PRESSURE                 | <input type="checkbox"/> PREMED / ANTIBIOTIC NEEDED         |
| <input type="checkbox"/> KIDNEY DISEASE                      | <input type="checkbox"/> Alzheimer's Disease                |

List ALL MEDICATION ( including: aspirin, birth control): \_\_\_\_\_

List ALL SUPPLEMENTS: \_\_\_\_\_

List ALL ALLERGIES: \_\_\_\_\_

Recent SURGERIES: \_\_\_\_\_

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Now being treated for: \_\_\_\_\_

**To the best of my knowledge, all of the above information is true and correct. If I have any change in my health, I will inform the doctor at the next appointment without fail.**

Patient/Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_