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? _____

Have you ever had botox or dermal fill?_____If not are you interested?_____

Health Information

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

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

Are you currently taking or have taken in the past any of the following Bisphosphonates: _____
( )Actonel ( )Fosamax ( )Boniva ( )Didronel ( )Aredia ( )Skelid ( )Reclast ( )Zometa ( )Fosamax Plus D
List ALL MEDICATION (including: aspirin, birth control): _____
_____
List ALL SUPPLEMENTS: _____
List ALL ALLERGIES: _____
Recent SURGERIES: _____
Physician Name: _____Phone: _____
Now being treated for _____
Have you ever had botox or dermal filler?_____If not are you interested?_____
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 fall.

Patient/Parent/Guardian Signature:_____ *Date*:_____

For office use only:
Blood Pressure:_____ Heart Rate:_____ sp02:_____