Allergies:_____

Please indicate any other medical conditions that we have not mentioned above: _____

_____

Please indicate any PRESCRIPTION or NON-PRESCRIPTION medications, pills or drugs which you are taking: _____

Do you have FREQUENT, SEVERE headaches, earaches, ear/throat infections?_____

Do you have any other questions or concerns?_____

Any other family members patients at our office?(please list)_____

How did you hear about us? _____

Do you have a specific need? If yes, please describe: _____

How often do you see the dentist? _____

When was your last dental visit?_____What was done?_____

When was the last time you had any dental x-ray taken?_____

Do your gums ever bleed, are they swollen or painful?_____	YES	NO
Do you ever have jaw joint pain? _____	YES	NO
Do you ever clench or grind your teeth? _____	YES	NO
Are you aware of any swelling, sore spots or lump(s) in your mouth? _____	YES	NO
Have you ever had any traumatic injury to your face? _____	YES	NO
Have you ever noticed any loose teeth or have any of your teeth shifted?_____	YES	NO
Have you been advised to take antibiotics before a dental appointment? _____	YES	NO
Do you smoke? If so, how much? _____	YES	NO
Do any of your teeth hurt/ache (e.g. sensitive to sweet, cold, hot, pressure)?_____	YES	NO

Please describe: _____

Have you had any kind of oral surgery? _____	YES	NO

Doctor who performed oral surgery:_____ Phone ( )_____

Have you ever had Orthodontics (Braces)?_____	YES	NO

Doctor's Name:_____ Phone ( )_____ Date of last exam: _____