Do you smoke? Y or N What?_____ How much?_____

Do you take medication or drugs? What And Why? _____

Are you supposed to take medication at this time and don't? Y or N _____

Do you have any drug allergies or have had a bad reaction to any medication? Y or N
If so what?_____

(Women) Do you suspect you are pregnant? _____ Are you nursing? Y or N

Reason for today's visit? _____

Former Dentist _____

Address _____

Date of last visit?_____What x-rays were taken?_____

DO YOU HAVE OR HAD PROBLEMS WITH ANY OF THE FOLLOWING

__Bad Breath	__Grinding Teeth	__Sensitivity to Cold
__Bleeding Gums	__Loose Teeth	__Sensitivity to Sweet
__Sores in Mouth	__Broken Filling	__Sensitivity to Biting
__Clicking or Popping Jay	__Perio Treatment	

Is there fluoride in your tap water at home or work? Y / N

How often do you brush your teeth? _____

How often do you floss your teeth? _____

Do you have braces? Y / N Did you ever have braces? Y / N When?_____

Is there anything else we should be aware of in order to meet your dental needs make your visits more comfortable? _____

The above information is accurate and complete to the best of my knowledge and will be kept in confidence. I will not hold my dentist or any staff responsible for any errors or omissions that I may have made in completion of this form.

_____ _____

(Patient or Guardian Signature) (Date)