

**FOR WOMEN ONLY:**

Are you taking birth control pills?  Yes  No

Are you nursing/breastfeeding?  Yes  No

Are you pregnant?  Yes  No

Expected delivery date: \_\_\_\_\_

Is there a possibility of pregnancy?  Yes  No

**NOTE:** Antibiotics (such as penicillin) may alter the effect of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

## Dental Health Information

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

Do you snore?  Yes  No

Name of your previous dentist \_\_\_\_\_

Do you have problems with bad breath?  Yes  No

Reason for today's visit? \_\_\_\_\_

Have you ever had an allergic reactions to a crown, metal filling or dental appliance?  Yes  No

Have you ever had an oral cancer screening?  Yes  No

Have you ever used an electric toothbrush?  Yes  No

How often do you floss your teeth? \_\_\_\_\_

Are your teeth sensitive to hot, cold or pressure?  Yes  No

Do your gums bleed when you brush?  Yes  No

On a scale from 1 to 10, with 10 being the highest, how important is your dental health to you?

Have you or a family member ever been treated for periodontal disease?  Yes  No

1    2    3    4    5    6    7    8    9    10

Have you ever had complications from an extraction?  Yes  No

If you could change something about your smile what would it be:

Have you ever had a popping or clicking near your ear when you chew?  Yes  No

Whiter

Are you prone to frequent headaches?  Yes  No

Straighter

Do you grind or clench your teeth?  Yes  No

Close space

Do you have sores, blisters or swelling on your gums lips or cheeks?  Yes  No

replace black mercury filling with tooth colored restorations

repair chipped teeth

replace missing teeth

less gums showing

Have you ever had orthodontic treatment?  Yes  No

replace old crowns or caps that don't match

Nothing, it's pretty Amazing

I certify that I have read and understand the questions above. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist or any other members of his/her staff responsible for any errors that I have made in the completion of this form.

Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian (if patient is a minor): \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

Dr. Signature: \_\_\_\_\_ Date: \_\_\_\_\_