BEARDEN FAMILY DENTISTRY

DENTAL / MEDICAL HISTORY

PERSONAL INFORMATION

Name: ____ Date of Birth: ____________________

DENTAL INFORMATION

What is the reason for today's visit? ❒ Full Exam ❒ Emergency ❒ Consultation

Are you in pain? ❒Yes ❒No If yes, for how long and in what area? ____

Former Dentist__________________________City, State_____________________Last Dental visit date __________

Date of last Oral X-rays_____________How often do you floss?_______________How often do you brush?__________

Type of toothbrush bristles do you use? ❒Hard ❒Medium ❒Soft Do you require premedication? ❒Yes ❒No

How do you rate your smile, 1 – 10? _____ What would you like to improve?___________________________________

Check all that apply:

Bad Breath	❒Yes ❒No	Loose teeth or broken filling	❒Yes ❒No	Sensitivity to sweets	❒Yes ❒No
Bleeding gums	❒Yes ❒No	Orthodontic Treatment	❒Yes ❒No	Sensitivity when biting	❒Yes ❒No
Blisters on lip/mouth	❒Yes ❒No	Pain around ear	❒Yes ❒No	Frequent headaches	❒Yes ❒No
Fingernail biting	❒Yes ❒No	Periodontal Treatment	❒Yes ❒No	Jaw, head or neck injuries	❒Yes ❒No
Grinding teeth	❒Yes ❒No	Sensitivity to cold	❒Yes ❒No	Jaw clicking and/or pain	❒Yes ❒No
Lip and cheek biting	❒Yes ❒No	Sensitivity to heat	❒Yes ❒No	Tooth pain	❒Yes ❒No

MEDICAL INFORMATION

Physicians Name: ____ Date of Last Visit: ________________

Are you currently under medical treatment? ❒Yes ❒No If yes, for what? ___________________________________

Do you use Tobacco? ❒Yes ❒No If yes, what and for how long? ____

Do you use Illicit drugs? ❒Yes ❒No If yes, what? ____

Are you pregnant? ❒Yes ❒No Are you nursing? ❒Yes ❒No

Have you had an allergic reaction to any of the following?

Local Anesthetics	❒Yes ❒No		
Penicillin or other Antibiotics	❒Yes ❒No		
Sulfa Drugs	❒Yes ❒No		
Barbiturates and/or Sedatives	❒Yes ❒No		
Sleep Apnea	❒Yes ❒No	If "Yes" do you wear a CPAP?	❒Yes ❒No
Lodine	❒Yes ❒No		
Aspirin	❒Yes ❒No		
Latex	❒Yes ❒No		

Are you currently taking any medications? If yes, please list: ____

____

Please list any other surgeries or medical conditions you have ever had: ______________________________________

____

MEDICAL INFORMATION - continued

Please mark any that apply:

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
AIDS	❐Yes	❐No	Diabetes	❐Yes	❐No	Nervous Problems	❐Yes	❐No
Anemia	❐Yes	❐No	Emphysema	❐Yes	❐No	Pacemaker	❐Yes	❐No
Arthritis	❐Yes	❐No	Epilepsy	❐Yes	❐No	Psychiatric care	❐Yes	❐No
Artificial Heart Valves	❐Yes	❐No	Fainting/Dizzy	❐Yes	❐No	Radiation	❐Yes	❐No
Artificial Joints	❐Yes	❐No	Glaucoma	❐Yes	❐No	Respiratory	❐Yes	❐No
Asthma	❐Yes	❐No	Headaches	❐Yes	❐No	Rheumatic Fever	❐Yes	❐No
Back Problems	❐Yes	❐No	Heart Murmur	❐Yes	❐No	Scarlet Fever	❐Yes	❐No
Bleeding abnormally,	❐Yes	❐No	Heart Problems	❐Yes	❐No	Shortness of breath	❐Yes	❐No
with surgery/extractions	❐Yes	❐No	Hepatitis	❐Yes	❐No	Sinus Trouble	❐Yes	❐No
Blood Disease	❐Yes	❐No	Herpes	❐Yes	❐No	Skin Rash	❐Yes	❐No
Cancer	❐Yes	❐No	High Blood Pressure	❐Yes	❐No	Stroke	❐Yes	❐No
Chemical Dependency	❐Yes	❐No	HIV Positive	❐Yes	❐No	Swelling of feet/ankles	❐Yes	❐No
Chemotherapy	❐Yes	❐No	Jaundice	❐Yes	❐No	Swollen Neck Glands	❐Yes	❐No
Chronic Fatigue Synd.	❐Yes	❐No	Jaw Pain	❐Yes	❐No	Thyroid Problems	❐Yes	❐No
Circulatory problems	❐Yes	❐No	Kidney Disease	❐Yes	❐No	Tonsillitis	❐Yes	❐No
Congenital Heart Issues	❐Yes	❐No	Liver Disease	❐Yes	❐No	Tuberculosis	❐Yes	❐No
Cortisone Treatment	❐Yes	❐No	Low Blood Pressure	❐Yes	❐No	Tumor/growth on head	❐Yes	❐No
Cough-persistent	❐Yes	❐No	Mitral Valve Prolapse	❐Yes	❐No	Ulcer	❐Yes	❐No
Taken Bisphosphonates	❐Yes	❐No	Venereal Disease	❐Yes	❐No	Human Papilloma Vaccine	❐Yes	❐No

- ❖ We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.
- ❖ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- ❖ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Please advise us in the future of any change in your dental or medical history or any medications you may be taking.

Patient/Guardian Signature: ____ Date: ____________________

Witness Signature: ____ Date: ___________________