FAMILY FIRST DENTAL
& Implant Center

PATIENT DENTAL HISTORY

Please read carefully and (✓) all that apply

☐ Bleeding gums
☐ Had gum surgery
☐ Had a root canal
☐ Clench/Grind teeth
☐ Hot/Cold sensitive
☐ Sweet/Sour sensitive
☐ Tumors/Cysts
☐ Head/Mouth Trauma
☐ Bite your lips or cheeks
☐ Frequent Headaches
☐ Prolonged Bleeding
☐ Wear Dentures/Partials
☐ Periodontal Disease
☐ Jaw gets locked or goes out
☐ Tobacco Use

Previous Dental Office: ______________________________ Office Number: (_____) ______________

Date of Last Exam: _____/_____/_____ Date of Last Cleaning: _____/_____/_____

What is the reason for your visit today? ☐ Check Up ☐ Toothache ☐ Consult ☐ Other ______________

Do you have any pain or discomfort now? ☐ Yes ☐ No If yes, explain: ______________

How many times per day do you brush your teeth? ☐ Zero ☐ 1 ☐ 2 ☐ 3 ☐ Other ______________

Do you floss? ☐ Yes ☐ No ☐ How often? ☐ Daily ☐ Weekly ☐ Other ______________

What changes would you like to make to the appearance of your teeth? ______________

PATIENT MEDICAL HISTORY

Please read carefully and (✓) all that apply

☐ Addiction to chemicals
☐ AIDS/HIV
☐ Anemia
☐ Asthma
☐ Arthritis
☐ Artificial Joints
☐ Cancer ______________
☐ Chest Pain
☐ Congenital Heart Defect
☐ Diabetes
☐ Epilepsy/Convulsions
☐ Empysema
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Heart Disease
☐ Heart Attack
☐ High Blood Pressure
☐ Hay Fever/Allergies
☐ Hepatitis __________
☐ Heart Murmur
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Leukemia
☐ Low Blood Pressure
☐ Mitral Valve Prolapse
☐ Nervous Disorder
☐ Pace Maker
☐ Psychiatric Treatment
☐ Radiation Therapy
☐ Respiratory Problem
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problem
☐ Stomach Ulcer
☐ Stroke
☐ Swollen Ankles
☐ Shortness if Breath
☐ Thyroid Disease
☐ Venereal Disease
☐ Other ______________

Rx ALLERGIES
☐ Codeine
☐ Penicillin
☐ Anesthetic
☐ Latex
☐ Other ______________

Official Use Only

Dr./RDH ______________

Date: ______________

☎ **EMERGENCY CONTACT** ______________ Phone Number: (_____) ______________

Relationship ______________ Mobile Number: (_____) ______________

Name of Physician: ______________ Office Number: (_____) ______________

Have you ever had complications following dental treatment? ☐ Yes ☐ No

If yes, explain: ______________

Have you been admitted to a hospital or needed emergency care in the past two years? ☐ Yes ☐ No

If yes, explain: ______________

Are you under the care of a physician? ☐ Yes ☐ No

If yes, explain: ______________

List ALL medications, vitamins, and herbal remedies that you are taking at this time: ______________

For women only: Are you pregnant or think you may be pregnant? ☐ Yes ☐ No If yes, Due Date: _____/_____/_____

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in The Statement of Privacy Policies, I hereby specifically authorize disclosure of my protected health carfe infoirmation to the person(s) listed below:

______________ Relationship: ______________
(Last) (First)

______________ Relationship: ______________
(Last) (First)

✘ Signature of Patient/Guardian: ______________ Date: ______________