CENTER ONE
DENTAL ASSOCIATES
Family, Implant & Cosmetic Dentistry

MEDICAL/DENTAL HISTORY

Patient Name: _____
Last First Initial Nickname Date of Birth

DENTAL HISTORY

Previous Dentist: _____ Phone: _____

Address: _____

When do you brush your teeth? ___ Upon arising ___ After each meal ___ Before going to bed ___ Upon arising and before going to bed

Do you eat between meals? ___ Yes ___ No
Do you eat sweets (candy, soda pop, chewing gum)? ___ Yes ___ No
Have you had cavities? ___ Yes ___ No
Have you had any teeth removed by extraction? ___ Yes ___ No
Was an appliance placed? ___ Yes ___ No
Have there been any injuries to teeth (falls, chips, blows)? ___ Yes ___ No
If yes, explain _____

Have you had periodontal treatment? ___ Yes ___ No
Have you ever received local anesthesia? ___ Yes ___ No
Do you floss or use mouth rinses? ___ Yes ___ No
Have you had any previous problems with dental treatment?
If yes, explain _____
Are you happy with your teeth? ___ Yes ___ No
If no, explain _____

MEDICAL HISTORY

Physician's Name: _____ Phone: _____

Are you currently under the care of a physician? ___ Yes ___ No If yes, explain _____
Have you ever had any serious illnesses? ___ Yes ___ No If yes, explain _____
Have you ever had surgery? ___ Yes ___ No If yes, explain _____
Have you ever been hospitalized? ___ Yes ___ No If yes, explain _____

Please list any MEDICATION(s) you are currently taking:

_____
_____
_____

Please list any ALLERGIES you have

_____
_____
_____

Have you had a history of any of the following?

- ☐ Acid reflux disease (GERD)
- ☐ ADD/ADHD
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Asthma
- ☐ Autism
- ☐ Autoimmune Disease
- ☐ Cancer
- ☐ Cardiac Transplant
- ☐ Chemical/Alcohol Dependency
- ☐ Congenital heart defects
- ☐ Diabetes If yes what age?____
- ☐ Dizziness
- ☐ High Blood Pressure
- ☐ Epilepsy
- ☐ Eyesight problems
- ☐ Fainting Spells
- ☐ Frequent headaches
- ☐ Hayfever
- ☐ Hearing loss
- ☐ Heart murmur
- ☐ Heart trouble
- ☐ Hepatitis
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Herpetic Lesions/Cold Sores
- ☐ HIV/AIDS
- ☐ Immunosuppression
- ☐ Eating Disorder
- ☐ Liver problems
- ☐ MRSA
- ☐ Psychiatric disorders
- ☐ Organ Transplants
- ☐ Prosthetic Replacement
- ☐ Radiation Therapy
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sexually Transmitted Diseases
- ☐ Severe/ prolonged bleeding
- ☐ Speech impairment
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Smoker
- ☐ Kidney Trouble

Additional Conditions/Comments:

_____

I certify that the above information is complete and accurate.

_____ _____ _____ _____

Date Patient Signature Date Dentist Signature