

DENTAL HEALTH HISTORY FORM

Patient Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____

Email Address: _____

Emergency Contact Information:

Name: _____ Relationship: _____

Phone Number: _____

Medical History:

- Yes No Do you have any heart conditions?
- Yes No Have you ever had a heart attack or stroke?
- Yes No Are you currently taking any medications?
- Yes No Do you have any allergies (medications, latex, etc.)?
- Yes No Do you have diabetes?
- Yes No Do you have asthma or other respiratory conditions?
- Yes No Do you have a history of bleeding disorders?
- Yes No Are you pregnant or nursing?
- Yes No Do you have any infectious diseases (e.g., HIV, hepatitis)?
- Yes No Have you ever had radiation therapy to the head or neck?
- Yes No Have you had any joint replacements or implants?
- Yes No Have you had any previous complications with dental treatment?
- Yes No Do you have high blood pressure?
- Yes No Do you use tobacco products?
- Yes No Do you consume alcohol regularly?

Dental History:

Date of last dental visit: _____

Have you had any serious problems associated with previous dental treatment? _____

Do your gums bleed when brushing or flossing? _____

Do you have pain or sensitivity in your teeth? _____

Have you noticed any loose teeth or changes in your bite? _____

Do you grind or clench your teeth? _____

Do you wear dentures or other dental appliances? _____

Are you interested in improving the appearance of your teeth? _____

Do you experience frequent headaches or jaw pain? _____

Have you had orthodontic treatment? _____

Consent and Acknowledgment:

I hereby certify that the above information is true and correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I consent to the examination and dental treatment by the dental professionals at this office. I acknowledge that I have had the opportunity to ask questions and have received satisfactory answers.

Patient Signature: _____ Date: _____

Parent/Guardian Signature (if patient is a minor): _____

Patient Signature

Dentist Signature

Signature: _____

Signature: _____

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