# DENTAL HEALTH HISTORY FORM

## PATIENT INFORMATION

<table>
<thead>
<tr>
<th>Date:</th>
<th>Telephone:</th>
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<tbody>
<tr>
<td>Name:</td>
<td>Date of Birth:</td>
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<tr>
<td>Address:</td>
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<tr>
<td>CITY</td>
<td>ST</td>
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<td>Reason for visit:</td>
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## PREVIOUS DENTIST INFORMATION

<table>
<thead>
<tr>
<th>Dentist:</th>
<th>Telephone:</th>
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<tr>
<td>Clinic/Facility:</td>
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<tr>
<td>Address:</td>
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<tr>
<td>CITY</td>
<td>ST</td>
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<tr>
<td>Reason for changing:</td>
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## DENTAL HISTORY

**Oral Health:** [ ] Excellent [ ] Good [ ] Fair [ ] Poor

**Date of Last Dental Visit:**

**Treatment Type:**

**Would you like to have a VisiLite oral cancer screening?** [ ] Yes [ ] No

*Note: Some insurance plans do not cover this service; please check your plan documents for details.*

- [ ] Yes [ ] No
  - Are you currently having dental discomfort? If yes, explain:
  - Any unhappy/unpleasant dental experiences? If yes, explain:
  - Any injuries to mouth/teeth/head? If yes, explain:
  - Any missing teeth other than wisdom teeth or orthodontic extractions?
  - Have missing teeth been replaced?
  - Orthodontic appliances now or in the past?
  - Gums bleed when brushing or flossing?
  - Concerned about gum disease? History of gum disease? [ ] Yes [ ] No
  - Any concerns about the appearance of your teeth?
  - Does it hurt to bite or chew?
  - Do you clench or grind your teeth? If so, do you wear a night guard or splint? [ ] Yes [ ] No
  - Do you want to become a regular continuing care patient in our practice?
  - Do you want your mouth properly restored and pain free?
  - Does any type of dental treatment make you nervous? If yes, please explain below:

**The most important concerns regarding my dental treatment are:**

**What factors are most important for your satisfaction with our office?**

**Any additional concerns/comments?**
**CHILD/MINOR PATIENTS:** PLEASE ANSWER THE FOLLOWING QUESTIONS:

- [ ] Y  N  Any mouth habits? (thumb sucking, nail biting, mouth breathing, nursing/bottle habits, pacifier, etc.)
- [ ] Y  N  Any unusual speech habits? If yes, explain: 
- [ ] Y  N  Any lost teeth?  If yes, list: 
- [ ] Y  N  Does the patient receive assistance with brushing and flossing?  If yes, how often?

## DENTAL HEALTH HISTORY FORM

**PRIMARY PHYSICIAN INFORMATION**

Physician:  
Telephone:  
Clinic/Facility:  

**MEDICAL HISTORY**

**GENERAL HEALTH:**  
[ ] Excellent  
[ ] Good  
[ ] Fair  
[ ] Poor

- [ ] Y  N  Under a physician’s care now?  
- [ ] Y  N  Any hospitalization in the past 5 years?  
- [ ] Y  N  Any serious illnesses/surgeries?  
- [ ] Y  N  Use tobacco in any form?  If Yes, Type:  
- [ ] Y  N  Pre-medication required before dental visits due to heart condition or artificial joint?  
- [ ] Y  N  Taking any prescription or daily OTC medications/drugs?  If yes, list details in the Medication Section.

**FEMALE PATIENTS:**  
- [ ] Y  N  Currently nursing?  
- [ ] Y  N  Currently pregnant? Due Date:  

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients?  [ ] Y  N  If yes, please describe:  

Is there anything important about your medical condition we have not asked?  [ ] Y  N  If yes, please describe:  

**ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY):**

- [ ] Acid Reflux  
- [ ] ADHD  
- [ ] AIDS/HIV  
- [ ] Anemia  
- [ ] Anorexia  
- [ ] Anxiety  
- [ ] Artifical Heart Valve  
- [ ] Artifical Joints  
- [ ] Arthritis  
- [ ] Asthma  
- [ ] Autism/Asperger’s  
- [ ] Bleeding Disorder  
- [ ] Asthma  
- [ ] Allergic  
- [ ] None

**ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):**

- [ ] Aspirin  
- [ ] Anesthetic – Local  
- [ ] Barbiturates  
- [ ] Other – Please List:  
- [ ] None
DENTAL HEALTH HISTORY FORM

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ ANTIbiotics/SULFA DRUGS ☐ ANTIHISTAMINES/ALLERGY ☐ DAILY ASPIRIN ☐ BLOOD PRESSURE MEDICATIONS
☐ BLOOD THINNERS ☐ CANCER/CHEMO MEDICATIONS ☐ CORTISONE/Steroids ☐ HEART MEDICATION/DIGITALIS
☐ INSULIN ☐ NITROGLYCERIN ☐ ORAL CONTRACEPTIVES ☐ OSTEOPOROSIS MEDICATIONS

☐ OTHER DIABETIC MEDICATIONS ☐ RECREATIONAL DRUGS ☐ THYROID MEDICATIONS ☐ TRANQUILIZERS
☐ OTHER (PLEASE LIST BELOW)

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<tr>
<th>DRUG NAME</th>
<th>DOSAGE</th>
<th>REASON PRESCRIBED</th>
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PATIENT AND (DIHFS) STAFF SIGNATURES

Date: Patient
Signature: ____________________________

Date: Reviewed By: ____________________________