the PLANO DENTIST

Dental Health History

(Please Print)

Patient First Name | Patient Last Name | Date

Please check Yes or No for those that apply to you.

- ☐ Sensitivity to: Hot Cold Sweet
- ☐ Chipped / Broken Teeth
- ☐ Crooked or Tipped Teeth
- ☐ Loose Teeth
- ☐ Missing or Spaces Between Teeth
- ☐ Catch Food Between Teeth
- ☐ Dry Mouth or Constantly Thirsty
- ☐ Smoke or Use Chewing Tobacco
- ☐ Bleeding, Swollen or Irritated Gums
- ☐ Dissatisfied With Appearance of My Teeth
- ☐ Frequent Headaches
- ☐ Jaw Joint Pain
- ☐ Grinding or Clenching Teeth
- ☐ Uncomfortable or Uneven When I Bite My Teeth Together
- ☐ Clicking or Popping of Jaw
- ☐ Difficulty Opening or Chewing

Please check Yes or No if you have, or have had any of the following?

- ☐ Dentures or Partials
- ☐ Braces or Clear Braces
- ☐ Periodontal Disease or Gum Treatments
- ☐ Fixed Bridge
- ☐ Dental Implants
- ☐ Crowns
- ☐ Veneers
- ☐ Jaw Surgery
- ☐ Root Canals
- ☐ Sleep Apnea
- ☐ C-PAP Machine or Oral Sleep Appliance
- ☐ Fear or Anxiety About Dental Treatment

If I could change my smile, I would:

- ☐ Make My Teeth Whiter
- ☐ Make My Teeth Straighter
- ☐ Close Spaces or Gaps That Bother Me
- ☐ Replace Dark Metal Fillings With Tooth Colored Fillings
- ☐ Fix My Teeth So I'm Not Embarrassed When I Smile
- ☐ Repair Chipped Teeth
- ☐ Replace Missing Teeth
- ☐ Replace Old Crowns That Look Dark or Don't Match
- ☐ Have a Smile Makeover
- ☐ Stop My Jaw From Hurting or Clicking

On a scale of 1 – 10, with 10 being the highest rating:

How important is your dental health to you? 1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10

Tell me about my options for replacing missing teeth with Dental Implants? ☐ Yes ☐ No

Tell me how I can straighten my teeth in 6 months instead of 2 years and if I'm a candidate? ☐ Yes ☐ No

Have you ever been sedated for dental treatment? ☐ Yes ☐ No

Are you interested in sedation options? ☐ Yes ☐ No

If you could whiten your teeth for an investment anyone could afford, would you be interested? ☐ Yes ☐ No

If this is your first time in our office please answer the following:

Date of last cleaning? ___ / ___ Date of last oral cancer screening? ___ / ___ Date of last complete x-rays? ___ / ___

What is the most important thing to you about your dental visit today: _____

Why did you leave your previous dentist? _____

the PLANO DENTIST

Medical Health History

(Please Print)

Patient First Name | Patient Last Name | Date

Address | Email | Phone

Please check any of the following that apply to you:

- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Diabetes
- ☐ Dizziness
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Heart Conditions
- ☐ Heart Lesions
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hepatitis: A B C
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Nervousness / Depression
- ☐ Pacemaker
- ☐ Periodontal Disease
- ☐ Radiation (Head / Neck)
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ STD _____
- ☐ Other _____

Women Only

- ☐ *Birth Control*
- ☐ *Nursing*
- ☐ *Pregnant*:

Delivery Date: _____

Do you have any of the following drug allergies?

- ☐ Aspirin
- ☐ Codeine
- ☐ Darvon
- ☐ Erythromycin
- ☐ Latex
- ☐ Anesthetic
- ☐ Nitrous Oxide
- ☐ Sulfa
- ☐ Percodan
- ☐ Penicillin
- ☐ Antibiotics
- ☐ Other Allergies

Please list other allergies.

_____

_____

_____

Please check any of the following drugs you have used at any time:

- ☐ Fosamax
- ☐ Aredia
- ☐ Didronel
- ☐ Actonel
- ☐ Zometa
- ☐ Skelid
- ☐ Boniva
- ☐ Bisphosphonates

List ALL medications you currently take. (Prescription & Over The Counter. Attach List if Needed)

_____ _____ _____ _____

_____ _____ _____ _____

Please list all surgeries with approximated dates:_____

_____

_____

Is there any other information regarding your past medical history we should know about?_____

_____

_____

If under physicians care please explain?_____ Physician's Name: _____

_____ Physician's Phone: _____

I certify the information recorded on this medical & dental form is correct. I understand it is my responsibility to notify PRACTICE NAME HERE of any changes. I understand if I withhold information regarding allergies, medical conditions, medications, or supplements; I agree not to hold The Plano Dentist or its employees liable in the event of death or injury.

Signature (Patient / Guardian) _____ Date: _____ Dentist Signature: _____