Patient: _____***date:___/___/___***

DENTAL HISTORY

Why did you come to the dentist today? _____
_____
Are you currently in pain? Yes No
Do you need to premedicate before dental treatment? Y N
Have you experienced problems associated with any previous dental work? Yes No
Do you or have you ever experienced pain/discomfort in your jaw joint? (TM]/TMD) Yes No
Your current dental health is Good Fair Poor
Do you floss daily? Yes No Brush Daily? Yes No
Type of bristles on your toothbrush? Soft Medium Hard
How often do you replace your toothbrush? _____
Do you use anything in addition to your brush and floss?___
If yes, what _____

Do your gums bleed? Yes No Itch? Yes No
Have you ever had periodontal disease? Yes No
Do any of your teeth feel loose? Yes No
*Are your teeth sensitive to: hot , cold, sweets, or anything else?*_____
Do you still have your wisdom teeth? Yes No
Previous/Present Dentist _____
(Circle one) Last visit date _____
*Why did you leave your previous dentist?*_____
_____
*What did you like most/least about any dentist you have seen?*_____
Are you pleased with your smile? Yes No
*If not what would you change?*_____

MEDICAL HISTORY

Do you have a personal physician? Yes No
Physician's Name _____
Address _____
Phone (____) _____ *Last visit?* _____
Your current physical health is: Good Fair Poor
Are you currently under a physicians care? Yes No
*Please explain:*_____
Do you smoke or use tobacco in any other form? Yes No

Are you allergic to any of the following?

Y N Aspirin Y N Erythromycin Y N Sedatives
Y N Jewelry Y N Barbiturates Y N Sulfa
Y N Codeine Y N Tetracycline Y N Latex
Y N Penicillin Y N Dental Anesthetic

*List any other medications that cause allergic reactions:*_____
_____

Women: *Are you taking birth control pills? Yes No*
Are you pregnant? Unsure Yes No
*Week #*_____ *Are you nursing? Yes No*

Are you taking any of the following?

Y N Acetaminophen
Y N Antibiotics
Y N Antihistamines
Y N Cold remedies
Y N Insulin/Diabetes Drugs
Y N Blood Pressure Medicine
Y N Digitalis/Heart Medicine
Y N Recreational Drugs
Y N Blood Thinners
Y N Nitroglycerin
Y N Aspirin
Y N Thyroid Medicine
Y N Tranquilizers
Y N Steroids/Cortisone

Are you currently taking any medication or "over the counter drug" not listed above? Y N
*If yes what:?*_____
*Have you ever taken Phen-Fen? Y N When:*_____
*Are you taking or have you ever taken bone enhancers (such as **Fosamax**) ?* _____

Do you or have you experienced the following?

Y N Abnormal Bleeding
Y N Alcohol Abuse
Y N Anemia
Y N Arthritis
Y N Artificial Bone/Joints
Y N Artificial Valve
Y N Asthma
Y N Blood Transfusions
Y N Cancer
Y N Chemotherapy
Y N Chicken Pox
Y N Colitis
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Drug Abuse
Y N Emphysema
Y N Epilepsy
Y N Fainting Spells
Y N Fever Blisters
Y N Glaucoma
Y N Hay Fever
Y N Headache
Y N Heart Attack
Y N Heart Murmur
Y N Heart Surgery
Y N Hemophilia
Y N Hepatitis
Y N Herpes
Y N High Blood Pressure
Y N HIV/AIDS
Y N Hospitalization
Y N Kidney Problems
Y N Liver Disease
Y N Low Blood Sugar
Y N Lupus
Y N Mitral Valve Prolapse
Y N Pacemaker
Y N Persistent Cough
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic Fever
Y N Scarlet Fever
Y N Seizures

Authorization

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest of confidence and it is my responsibility to inform Dr. Williamson's office of any change in my medical status. I authorize the dental staff to perform the necessary dental services I may need. My method of payment will be: _____.

_____ ___/___/___
Signature date

Updated: ___/___/____ By: _____ Patient: _____
Updated: ___/___/____ By: _____ Patient: _____
Updated: ___/___/____ By: _____ Patient: _____
email address: _____