CRISTEL
FAMILY DENTISTRY

DENTAL HISTORY

What are your immediate dental concerns today? _____

Approximate date of your last dental visit _____ Reason_____

Previous Dental Provider _____ Phone #_____

Have you had an unfavorable reaction to past dental treatment or anesthetic?	YES	NO
Do you have anxiety around receiving dental treatment?	YES	NO
Have you had orthodontic treatment? If YES, When_____ Dr._____	YES	NO
Do your gums bleed when you brush or floss?	YES	NO
Have you had periodontal (gum) disease?	YES	NO
If so, did you receive treatment?	YES	NO
Are your teeth or mouth especially sensitive to (circle) cold hot chewing	YES	NO
Do you clench or grind your teeth during the day or night?	YES	NO
Do you have: (circle) muscle soreness tension headaches jaw joint noise/pain	YES	NO
Have you been treated for the above problems?	YES	NO
Are you dissatisfied in the appearance of your teeth? (color, shape, crowding)	YES	NO
Please describe_____		
Have financial considerations prevented you from following through with your dental needs?	YES	NO
Are you interested in learning more about financing options?	YES	NO

MEDICAL HISTORY

Physician_____ Address _____

Are you currently under the care of a physician? YES NO Reason _____

Do you have or have had any of the following:

Heart disease	YES	NO	Hepatitis	YES	NO	Sinus trouble	YES	NO
Bleeding disorder	YES	NO	AIDS or HIV	YES	NO	Asthma	YES	NO
Abnormal blood pressure	YES	NO	Arthritis	YES	NO	Tobacco use	YES	NO
Tuberculosis	YES	NO	Anxiety/Depression	YES	NO	Osteoporosis	YES	NO
Diabetes	YES	NO	Serious Accident	YES	NO	Pregnant	YES	NO
Cancer	YES	NO	Stroke	YES	NO	Sleep Apnea	YES.	NO

Any other medical conditions or limitations?_____

Do you have implants or joint replacement (hip, knee, prosthetic, heart value)? YES NO

Any allergies? Penicillin, Anesthetics, latex, etc._____

Are you currently taking any medications? YES NO (please list)_____

Medication_____ Reason_____

Medication_____ Reason_____

Signature_____ Date_____