



4. Please note any prescription medication, recreational substances, or supplements: \*We can scan a list if you have one\*

Name \_\_\_\_\_ Reason \_\_\_\_\_  
Name \_\_\_\_\_ Reason \_\_\_\_\_  
Name \_\_\_\_\_ Reason \_\_\_\_\_  
Name \_\_\_\_\_ Reason \_\_\_\_\_  
Name \_\_\_\_\_ Reason \_\_\_\_\_

5. Have you ever been advised to take antibiotics prior to dental treatment? Yes No Hip / Knee / Heart Valve or Defect

6. Do you have any allergies (food, medication, latex)? \_\_\_\_\_

7. Have you ever had a reaction to dental local anesthetic? Yes No

8. Do you smoke or use tobacco? Yes No Previously, but quit If yes, how much? \_\_\_\_\_

9. Do you exercise? Yes No If yes, how frequently? \_\_\_\_\_

10. Female patients: Are you pregnant or think you may be pregnant? Yes No Breastfeeding? Yes No

**DENTAL HISTORY**

What brings you in today? \_\_\_\_\_

Date of last dental visit: \_\_\_\_\_ What was done at your last dental visit? \_\_\_\_\_

Previous Dentist for Records? \_\_\_\_\_

Do you have regular dental hygiene appointments? Yes No If yes, how often? \_\_\_\_\_

What toothbrush do you use? Philips Sonicare Oral B Power Manual: reg / soft \_\_\_\_\_

How frequently do you floss? \_\_\_\_\_

Do you experience tooth sensitivity to hot or cold temperatures? \_\_\_\_\_

Do you grind or clench your teeth? Yes No Do you have a nightguard? Yes No

Do you suffer from: Headaches? Yes No Earaches? Yes No Neck aches? Yes No

Do you experience dry mouth? Yes No

Is there anything else we should know in order to keep your dental experience safe and comfortable?

**AUTHORIZATION**

I hereby certify that the information provided above is correct and is for the benefit of my treatment. If I have a change in my health, I will inform the office at my next dental appointment. I consent to the release of medical information from my medical doctor or other health care provider as required by the Dentist. I authorize the diagnosis of my dental health by means of radiographs (including x-rays), photographs or other diagnostic aids deemed appropriate. I understand that it is my responsibility to pay for all fees incurred for myself and any dependents, including any fees not covered by a dental plan (if applicable).

*Please note our Cancellation Policy: To avoid a fee, our clinic requires a minimum of 24 HOURS NOTICE in order to makes changes to your scheduled appointment.*

x \_\_\_\_\_

Signature of Patient or Parent/Guardian

\_\_\_\_\_

Today's Date