Smiles at San Tan Ranch
Your Neighbor! Your Dentist!

Dental History	Yes	No	Health History	Yes	No
Are your teeth sensitive to:			Are you under a physicians care at this time?		
Heat?			Please list the name and phone for your MD:		
Cold?					
Sweets?					
Pressure?					
Does food catch between your teeth?			Have you ever been treated for a bone disorder such as osteoporosis?		
Do your gums bleed when brushing or flossing?					
Do you feel you have bad breath?			Have you ever been treated for any kind of cancer?		
Have you ever had a "deep cleaning"?			Have you ever received radiation and/or chemotherapy?		
Do you have any problems with your jaw joint (TMJ)?			Do you have or have you ever had:		
Clicking?			Heart murmur/Mitral Valve Prolapse?		
Jaw Pain (Joints, ear side of face)?			Respiratory Conditions including asthma?		
Difficulty chewing?			Rheumatic Fever?		
Locking open or closed?			Epilepsy?		
Headaches when awakening?			High Blood Pressure?		
Have you ever had an adverse reaction to anesthetics?			Low Blood Pressure?		
If yes, please describe:			Artificial Joints?		
			Pacemaker?		
Do you currently or have you ever used tobacco products?			Heart Disease ?		
Describe your tobacco use:			Heart Attack?		
When was your last oral cancer screening?					
Do you have any lumps, bumps or sores in your mouth that have not healed withint 10 days?			Hepatitis (Please circle) A B C		
Do you have missing teeth?			HIV/AIDS?		
How long have they been missing?		Years	Prolonged Bleeding?		
Rate your smile on a scale of 1-10			Healing Complictions?		
What would make your smile a 10?			Drug Allergies: Please list		
Why did you leave your last dentist?					
			Are you diabetic? If yes, Type I or Type II		
When was your last dental appointment?		Months	Is your diabetes well controlled?		
When was you last dental cleaning?		Months	Do you have a sugar source with you at all times?		
Have you ever have orthodontic treatment?			Did you know there is a direct link between diabetes and gum disease?		
Rate your anxiety you have about dental treatment 1-10			Women:		
Are you interested in learning more about sedation options for dental care?			Are you pregnant?		
What is your chief dental concern?			Are you nursing?		
			Are you taking birth control pills?		
Please list all medications you are taking including over the counter medications:			What can we do to make your appointment more comfortable?		

By signing below you acknowledge you have provided an accurate health history to your dental office. Please keep your dental team informed of any changes in your health as changes can affect your oral health. Additionally, many diseases first symptoms present in the oral cavity and you may be asked to see your medical doctor for diagnosis.

Signature of Patient or Legal Guardian of Patient

Date

Patient Printed Name

Printed Name of Guardian

Provider Reviewed and Date