Dental History

Are you in pain? ☐ Yes ☐ No How Long?_____

Please indicate any of the following problems:

- ☐ Discomfort, clicking, or popping in jaw
- ☐ Red, swollen, or bleeding gums
- ☐ Sensitive tooth, teeth, or gums
- ☐ Blisters/Sores in or around mouth
- ☐ Lost/Broken fillings
- ☐ Teeth grinding
- ☐ Bad breath
- ☐ Other:_____

Last Dental Exam:_____/_____
Month Year

Times per day you brush:_____ Times per week you floss:_____

Medical History

What medications are you taking? ☐ Nerve pills ☐ Pain killers(including aspirin) ☐ Muscle relaxers ☐ Blood thinners ☐ Tranquillizers ☐ Insulin ☐ Other:_____

Do you have or have you had any of the following diseases, conditions, or procedures?

Y/N Heart Attack/Stroke	**Y/N** Thyroid Problems	**Y/N** Cancer/Tumors
Y/N Heart Surg./Pacemaker	**Y/N** Kidney Problems	**Y/N** Heart Murmur
Y/N Liver Problems	**Y/N** Hepatitis	**Y/N** Fainting/Seizures/Epilepsy
Y/N Rheumatic Fever	**Y/N** Respiratory Problems	**Y/N** HIV+AIDS/ARC
Y/N Asthma	**Y/N** Mitral Valve Prolapse	**Y/N** Sinus Problems
Y/N Difficulty Breathing	**Y/N** Artificial Valves	**Y/N** Arthritis/Rheumatism
Y/N Diabetes/Hypoglycemia	**Y/N** Artificial Bones/Joints	**Y/N** Psychiatric Problems
Y/N Congenital Heart Defect	**Y/N** Emphysema	**Y/N** Venereal Disease
Y/N Severe Headaches	**Y/N** Bleeding Problems	**Y/N** Alcohol/Drug Abuse
Y/N Tuberculosis TB	**Y/N** Frequent Neck Pain	**Y/N** Nervousness
Y/N Scarlet Fever	**Y/N** Leukemia	**Y/N** Anemia
Y/N Glaucoma	**Y/N** Chemotherapy	**Y/N** Stomach Problems/Ulcers
Y/N High/Low Blood Pressure	**Y/N** Dry Mouth/Excessive Thirst	

Do you require premedication? ☐ Yes ☐ No ☐ Don't Know

Family history of: ☐ Diabetes ☐ Heart Problems ☐ Cancer/Tumors

Are you allergic to any of the following? ☐ Latex ☐ Penicillin ☐ Tetracycline ☐ Dental Anesthetics ☐ Aspirin ☐ Other:_____

Do you use tobacco? ☐No ☐Yes/How much?_____ How Long?_____

For Women: Are you taking Birth Control pills? ☐Yes ☐No

Are you pregnant? ☐No ☐Yes/How long?_____ Are you nursing? ☐Yes ☐No

I authorize the doctor and/or staff to take x-rays, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated and further authorize and consent that the doctor employ such assistance as deemed fit. I understand that the doctor will make decisions based on my health needs and not the limitations of my benefits, and that I am responsible for payment for dental services provided in this office, due and payable at the time of service. I understand that the doctor and/or staff of Gentle Dental Associates is not responsible for the limitations of my benefits, and my responsibility to pay for services is not conditioned on any attempt to assist me with understanding my benefits.

Signature:_____ Date:_____