It is important that I know about your Medical and Dental History. These facts have a direct bearing on your Dental Health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely fill out this questionnaire.

DENTAL HISTORY

	YES	NO
HOW LONG SINCE you have seen a Dentist?		
Last COMPLETE Dental Exam Date:		
Last FULL MOUTH X-RAYS - Date:		
Are you having PROBLEMS now?		
What?		
Is your present dental health POOR?		
Do you wear DENTURES? (Partials or Full)		
Are you UNHAPPY with your dentures?		
Would you like to know more about PERMANENT REPLACEMENTS?		
Are you APPREHENSIVE about dental treatment?		
Have you had any PERIODONTAL (Gum) Treatment?		
Do your gums BLEED, or feel TENDER or IRRITATED?		
Are your teeth SENSITIVE to hot, cold, sweets, pressure? (circle)		
Are you UNHAPPY with the APPEARANCE of your teeth?		
Are you aware of GRINDING or CLENCHING your teeth?		
Do you have HEADACHES, EARACHES or NECK PAINS?		
Have you worn BRACES on your teeth?		
Do you have DISCOLORED teeth that bother you?		
Would you like your smile to LOOK BETTER or DIFFERENT?		
Do you REGULARLY use DENTAL FLOSS?		

Name of Previous Dentist:

City/State

How do you feel about your teeth?

Please RANK following in the order in which they would KEEP YOUR FROM having dental treatment.

COST of treatment #______ MISSING work time #______

FEAR of Pain #______ LACK of concern #______

MEDICAL HISTORY

	YES	NO
DO YOU HAVE ANY CURRENT HEALTH PROBLEMS?		
Are you under a PHYSICIAN'S CARE now?		
For WHAT?		
Are you PREGNANT?		

Are you taking any MEDICATIONS? yes no

Please List:

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR PRESENTLY HAVE:

A.I.D.S.	DIABETES	HIV
ALCOHOLISM	DRUG ADDICTION	KIDNEY TROUBLE
ALLERGIES OR HIVES	EMPHYSEMA	LIVER DISEASE
ANEMIA	EPILEPSY OR SEIZURES	LUPUS
ANGINA PECTORIS	FEVER BLISTERS	MITRAL VALVE PROLAPSE
ARTHRITIS	GLAUCOMA	NERVOUSNESS
ARTIFICIAL HEART VALVE	HAY FEVER	PAIN IN JAW JOINTS
ARTIFICAL JOINTS	HEART ATTACK	PSYCHIATRIC TREATMENT
ASTHMA	HEART DISEASE	RADIATION TREATMENT
BLOOD TRANSFUSION	HEART MURMUR	RHEUMATIC FEVER
BRUISE EASILY	HEART PACEMAKER	SINUS TROUBLE
CANCER	HEART SURGERY	THYROID DISEASE
CHEMOTHERAPY	HEMOPHILIA (FREE BLEEDER)	TUBERCULOSIS (TB)
CONGENITAL HEART LESIONS	HEPATITIS A (INFECTIOUS)	ULCERS
CORTISONE MEDICATIONS	HEPATITIS B (SERUM)	VENEREAL DISEASE
COSMETIC SURGERY	HIGH BLOOD PRESSURE	(SYPHILIS, GONORRHEA, HERPES, ETC.)

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

Aspirin	Local Anesthetic	Erythromycin
Nitrous Oxide	Codeine	Penicillin

Are you aware of being allergic to any other medications or substances?

If yes, Please list:

Is there any other Medical or Dental information that you feel I should know about?

FAMILY PHYSICIAN PHONE #: ( )

ADDRESS: CITY: STATE:

The above information is accurate and complete to the best of my knowledge. I will not hold Longbranch Dental Center or its employees responsible for any errors or omissions that I may have made in the completion of this form.

DATE:______________ SIGNATURE:____________________