PATIENT DENTAL HISTORY		
Name *(Last, First, M.I.):*	☐ M ☐ F	DOB:
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Reason for today's visit:		
Referring Dentist / Individual:		Phone:
Date of last dental visit:		

PLEASE CHECK ALL THAT APPLY		
☐ bad breath	☐ food collection between the teeth	☐ snoring
☐ bleeding gums when brush/floss	☐ surgical implants / fixtures in mouth	☐ pain when brushing
☐blister or sores on lips/mouth	☐ grinding/ clenching	☐ had orthodontic treatment
☐ burning sensation on the tongue	☐ swollen/tender gums	☐ pain (joint, ear, side of face)
☐ chew on one side of the mouth	☐ jaw pain	☐ past/present gum problems
☐ smoke cigarette/pipe/cigar	☐ jaw tiredness	☐ sensitivity to cold
☐ clicking or popping in the jaw	☐ lip or cheek biting	☐ sensitivity to hot
☐ dry mouth	☐ loose or broken teeth	☐ sensitivity to sweet/sour
☐ fingernail biting	☐ mouth breathing	☐ sensitivity when biting/chewing
☐ dentures/partials	☐ wisdom teeth present	☐ frequent headaches
☐ difficulty opening/closing	☐ difficulty chewing	☐ yellowing of teeth

PATIENT MEDICAL HISTORY (*CHECK ALL THAT APPLY)*		
☐ high blood pressure	☐ arthritis	☐ cancer
☐ heart attack	☐ joint replacement/implant	☐ radiation therapy
☐ heart murmur	☐ pins, plates, broken bones	☐ AIDS or HIV infection
☐ heart disease	☐ fainting/seizures	☐ sexually transmitted disease
☐ heart trouble	☐ asthma	☐ hepatitis/jaundice
☐ chest pains	☐ emphysema	☐ liver disease
☐ cardiac pacemaker	☐ respiratory troubles	☐ stomach troubles/ulcers
☐ mitral valve prolapsed	☐ hay fever/ allergies	☐ tuberculosis
☐ Angina	☐ epilepsy/convulsions	☐ glaucoma
☐ Rheumatic fever	☐ leukemia	☐ recent weight loss
☐ easily winded	☐ diabetes	☐ blood disorders
☐ stroke	☐ kidney disease	☐ mental health issues
☐ low blood pressure	☐ thyroid problem	☐ migraine headaches
☐ swollen ankles	☐ anemia	☐ other _____

PATIENT ALLERGIES		
☐ local anesthetic (ex. Novocain)	☐ barbiturates	☐ aspirin
☐ penicillin or any other antibiotics	☐ sedatives	☐ any metals (ex. Nickel, Mercury)
☐ sulfa drugs	☐ iodine	☐ latex rubber
☐ other:		

MEDICATIONS (*PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING*)

AUTHORIZATION AND RELEASE	
I certify that I have answered the above questions accurately, to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. If I have any changes in my health status or if my medications change, I shall inform ASK Dental Care at or before my next appointment. I authorize ASK Dental Care to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during such dental care to third party payers and/or health practitioners.	
Signature of Patient:	Date: