UPTOWN Dental
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Dental History

I am changing dentists because:

check all that apply

__ Recently moved into this area from

__ Dr/Staff personality/communication problem

__ Inadequate Care

__ Fee Concern

__ I'm fleeing managed care/ don't want a "list" dentist

__ To find a dentist who understands my needs

I have avoided dental care in the past because: check all that apply

__ Fear of_____

__ Time Commitment

__ Financial Commitment

__ No perceived need

__ Trust factor

If you could change anything about **your smile,** what would you change?_____

How did you hear about us?

__ Metro Directories Phone Book

__ Town Lake Phone Book

__ Town Laker

__ Sixes Living

__ Chamber Meeting

__ Daycare / School Presentation

School Name_____

__ Flyer

Location_____

__ Another Doctor / Dentist

Location_____

__ Health Fair

Company Name_____

__ Other_____

Authorization & Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I agree to a dental examination any necessary records that are necessary for an accurate diagnosis. I authorize the dentist to use any treatment records, x-rays, models or photos for scientific, teaching or promotional purposes.

X _____ _____
Signature of Patient or Parent if Minor Date

Patient Medical History

Name _____ **Age** _____ **Date** _____

	Yes	No
1. Are you in good health	___	___
2. Have there been any changes in your general health within the past year?	___	___
3. Date of your last physical exam _____		
4. Physician's Name _____ Address _____ Phone No. _____		
5. Are you now under the care of a physician?	___	___
6. Have you ever been hospitalized for any surgical operation or serious illness?	___	___
7. Are you taking any medicines including nonprescription medicines? If yes, what are you taking? _____	___	___
8. Bruise easily or abnormal bleeding?	___	___
9. Have you ever required a blood transfusion	___	___
10. Have you had a recent weight loss?	___	___
11. Have you ever taken Fen-Fen or Redux?	___	___
12. Have you ever had biphosponate drugs for Cancer or Osteoporosis?	___	___
13. Do you use tobacco?	___	___
14. Do you or have you used controlled drugs?	___	___
15. Are you wearing contact lenses?	___	___
16. Do you have any disease, condition or problem not listed above that you think I should know about?	___	___
17. Women: Are you pregnant?	___	___
Are you nursing?	___	___
Taking birth control pills?	___	___
18. Are you allergic to or have you had serious reactions (other than stomach upset) to:		
Penicillin or other antibiotics	___	___
Sulfa Drugs	___	___
Barbiturates, sedatives or sleeping pills	___	___
Aspirin or similar NSAIDs	___	___
Iodine or shellfish	___	___
Any metals	___	___
Latex / rubber	___	___
Other (please list) _____		
19. Do you have or have you had the following:		
Rheumatic Heart disease or rheumatic fever	___	___
Scarlet Fever	___	___
Heart defect/murmur, Mitral valve prolapse	___	___
Heart surgery, trouble, attack, or angina	___	___
Chest pain, shortness of breath, pacemaker	___	___
High / Low blood pressure, hepatitis, jaundice or liver disease	___	___

Yes	No	
___	___	Stroke
___	___	Sinus trouble
___	___	Lung or breathing problem
___	___	Asthma or hay fever
___	___	Hives or skin rash
___	___	Fainting or dizzy spells
___	___	Diabetes
___	___	AIDS or HIV infection
___	___	Thyroid problems
___	___	Allergies
___	___	Arthritis, rheumatism, fibromyalgia
___	___	Joint replacement or any implant
___	___	Stomach ulcer, reflux, IBS, Crohn's
___	___	Kidney trouble
___	___	Tuberculosis, persistent or bloody cough
___	___	Chemotherapy for cancer or leukemia
___	___	Sexually transmitted disease
___	___	Epilepsy or seizures, MLS
___	___	Anemia or blood disorders
___	___	Glaucoma
___	___	Nervousness or phobias
___	___	Tumors or Cancer
___	___	Mental Health care: Diagnosis _____
___	___	Back problems
___	___	Chemical dependency, addictions
___	___	Cortisone treatment
___	___	Cold sores / fever treatment
___	___	Hypoglycemia
___	___	Eating disorders, bulimia, anorexia
___	___	Chronic pain condition
___	___	Head or neck trauma, whiplash
___	___	Hyperchondriosis
___	___	Other (please list) _____

Patient Dental History

Reason for visit _____ Date of Visit _____
What was done? _____

Previous Dentist name / location _____
Date of last complete series of dental x-rays _____

Circle all that you are concerned about / currently have:

Sensitivity to hot/cold sweets

Tooth pain/ache	Want to save teeth	Clicking Jaw	Missing teeth
Cavities	Dream teeth fall out	Spacing	Crooked teeth
Broken teeth	Snoring/apnea	Headaches	Fear of dentists
Dark teeth	Poor dentistry	Pain to bite	Grinding/clenching
Bad breath	Gum disease	Recession	Want whiter teeth
Loose teeth	Broken fillings	Nothing	Want gentle dentist
Jaw or face pain	Ugly teeth	Bleeding gums	Cosmetic dentistry