Dental Health History

(Please Print)

Patient First Name | Patient Last Name | Date

Please check Yes or No for those that apply to you.

YES	NO		YES	NO	
☐	☐	Sensitivity to: Hot Cold Sweet	☐	☐	Bleeding, Swollen or Irritated Gums
☐	☐	Chipped / Broken Teeth	☐	☐	Dissatisfied With Appearance of My Teeth
☐	☐	Crooked or Tipped Teeth	☐	☐	Frequent Headaches
☐	☐	Loose Teeth	☐	☐	Jaw Joint Pain
☐	☐	Missing or Spaces Between Teeth	☐	☐	Grinding or Clenching Teeth
☐	☐	Catch Food Between Teeth	☐	☐	Uncomfortable or Uneven When I Bite My Teeth Together
☐	☐	Dry Mouth or Constantly Thirsty	☐	☐	Clicking or Popping of Jaw
☐	☐	Smoke or Use Chewing Tobacco	☐	☐	Difficulty Opening or Chewing

Please check Yes or No if you have, or have had any of the following?

YES	NO		YES	NO	
☐	☐	Dentures or Partials	☐	☐	Veneers
☐	☐	Braces or Clear Braces	☐	☐	Jaw Surgery
☐	☐	Periodontal Disease or Gum Treatments	☐	☐	Root Canals
☐	☐	Fixed Bridge	☐	☐	Sleep Apnea
☐	☐	Dental Implants	☐	☐	C-PAP Machine or Oral Sleep Appliance
☐	☐	Crowns	☐	☐	Fear or Anxiety About Dental Treatment

If I could change my smile, I would:

☐ Make My Teeth Whiter
☐ Make My Teeth Straighter
☐ Close Spaces or Gaps That Bother Me
☐ Replace Dark Metal Fillings With Tooth Colored Fillings
☐ Fix My Teeth So I'm Not Embarrassed When I Smile
☐ Repair Chipped Teeth
☐ Replace Missing Teeth
☐ Replace Old Crowns That Look Dark or Don't Match
☐ Have a Smile Makeover
☐ Stop My Jaw From Hurting or Clicking

On a scale of 1 – 10, with 10 being the highest rating:

How important is your dental health to you? 1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10

Tell me about my options for replacing missing teeth with Dental Implants? ☐ Yes ☐ No

Have you ever been sedated for dental treatment? ☐ Yes ☐ No

Are you interested in sedation options? ☐ Yes ☐ No

If you could whiten your teeth for a investment anyone could afford, would you be interested? ☐ Yes ☐ No

Are you interested in whitening your teeth? ☐ Yes ☐ No

If this is your first time in our office please answer the following:

Date of last cleaning? ___ / ___ Date of last oral cancer screening? ___ / ___ Date of last complete x-rays? ___ / ___

What is the most important thing to you about your dental visit today: _____

Why did you leave your previous dentist? _____

Medical Health History

(Please Print)

Patient First Name | Patient Last Name | Date

Address | Email | Phone

Please check Yes or No for those that apply to you.

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	Anemia	☐	☐	Emphysema	☐	☐	Kidney Disease	☐	☐	Seizures
☐	☐	Arthritis	☐	☐	Excessive Bleeding	☐	☐	Liver Disease	☐	☐	Stomach Problems
☐	☐	Artificial Heart Valve	☐	☐	Fainting	☐	☐	Low Blood Pressure	☐	☐	Stroke
☐	☐	Artificial Joints	☐	☐	Glaucoma	☐	☐	Mitral Valve Prolapse	☐	☐	Thyroid Disease
☐	☐	Asthma	☐	☐	Heart Conditions	☐	☐	Nervousness / Depression	☐	☐	Tuberculosis
☐	☐	Blood Disease	☐	☐	Heart Lesions	☐	☐	Pacemaker	☐	☐	Ulcers
☐	☐	Bruise Easily	☐	☐	Heart Murmur	☐	☐	Periodontal Disease	☐	☐	Venereal Disease
☐	☐	Cancer	☐	☐	Heart Surgery	☐	☐	Radiation (Head / Neck)	***Women Only***		
☐	☐	Chemotherapy	☐	☐	Hepatitis: A B C	☐	☐	Respiratory Problems	☐	☐	*Birth Control*
☐	☐	Diabetes	☐	☐	High Blood Pressure	☐	☐	Rheumatic Fever	☐	☐	*Nursing*
☐	☐	Dizziness	☐	☐	HIV Positive	☐	☐	Rheumatism	☐	☐	*Pregnant*:
			☐	☐	Jaundice	☐	☐	Scarlet Fever	*Delivery Date*: _____		

Do you have any of the following drug allergies?

YES	NO		YES	NO		YES	NO	
☐	☐	Aspirin	☐	☐	Latex	☐	☐	Percodan
☐	☐	Codeine	☐	☐	Anesthetic	☐	☐	Penicillin
☐	☐	Darvon	☐	☐	Nitrous Oxide	☐	☐	Antibiotics
☐	☐	Erythromycin	☐	☐	Sulfa	☐	☐	Other Allergies

Please list other allergies.

_____

_____

_____

Please check any of the following drugs you have used at any time:

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	Fosamax	☐	☐	Didronel	☐	☐	Zometa	☐	☐	Boniva
☐	☐	Aredia	☐	☐	Actonel	☐	☐	Skelid	☐	☐	Bisphosphonates

List ALL medications you currently take. (Prescription & Over The Counter. Attach List if Needed)

_____ _____ _____ _____

_____ _____ _____ _____

Using The Epworth Sleepiness Scale of 0 – 3 How likely are you to doze off or fall asleep in the following situations?
No chance of dozing = 0 Slight chance of dozing = 1 Moderate chance of dozing = 2 High chance of dozing = 3

__ Sitting and Reading
__ Watching TV
__ Sitting inactive in a public place, ie... theater or a meeting
__ As a passenger in a car for an hour without a break
__ Lying down to rest in the afternoon if conditions permit
__ Sitting and talking to someone
__ Sitting quietly after lunch without alcohol
__ In a car, while stopped for a few minutes in traffic
__ **TOTAL SCORE**

If under physicians care please explain?_____ Physician's Name: _____

_____ Physician's Phone: _____

I certify the information recorded on this medical & dental form is correct. I understand it is my responsibility to notify INFINITY DENTAL PLLC of any changes. I understand if I withhold information regarding allergies, medical conditions, medications, or supplements; I agree not to hold INFINITY DENTAL PLLC or its employees liable in the event of death or injury.

Signature (Patient / Guardian) _____ Date: _____ Dentist Signature: _____