DOOR to DOOR
DENTAL CARE

Today's date:_____

DENTAL HISTORY

Patient's last name: First: Middle:		Birth date: / /
Patient Address:	Phone:	
Reason for today's visit:		
Former or Current Dentist:		
Date of last dental care:	Date of last dental x-rays:	

Check box if you have had problems with any of the following:

❑ Bad breath	❑ Grinding teeth	❑ Jaw or mouth pain
❑ Bleeding gums	❑ Loose teeth or broken fillings	❑ Suffer from dry mouth
❑ Clicking or popping jaw	❑ Periodontal treatment	❑ Have sleep apnea
❑ Food collection between teeth	❑ Sores or growths in your mouth	❑ Snore

How often do you floss:	How often do you brush:

MEDICAL HISTORY

Physician's name:		Date of last visit:
Have you had any serious illnesses or operations?	❑ Yes ❑ No	If yes, describe:
Have you ever had a blood transfusion?	❑ Yes ❑ No	If yes, give approximate dates:

Check box if you have had problems with any of the following:

❑ AIDS or HIV positive	❑ Chemo or radiation therapy	❑ Heart murmur	❑ Psychiatric care
❑ Anemia	❑ Circulatory problems	❑ Hemophilia	❑ Respiratory disease
❑ Arthritis, Rheumatism	❑ Cortisone treatments	❑ Hepatitis	❑ Rheumatic fever
❑ Artificial heart valves	❑ Cough, persistent	❑ High blood pressure	❑ Scarlet fever
❑ Artificial joints or implants	❑ Diabetes	❑ Jaw pain	❑ Stroke
❑ Asthma	❑ Epilepsy or seizures	❑ Kidney disease	❑ Thyroid problems
❑ Back problems	❑ Fainting or dizzy spells	❑ Liver disease	❑ Tobacco habit
❑ Blood disease	❑ Glaucoma	❑ Mitral valve prolapse	❑ Tuberculosis
_____	❑ Headaches	❑ Nervous problems	❑ Ulcer
❑ Cancer	❑ Heart failure, disease, attack	❑ Osteoporosis	❑ Venereal disease
❑ Chemical dependency	_____	❑ Pacemaker	❑ Other _____

MEDICATIONS	ALLERGIES	
Please list prescription or non-prescription medications:	❑ Aspirin	❑ Local anesthetic
	❑ Barbiturates (sleeping pills)	❑ Penicillin
	❑ Codeine	❑ Sulfa
	❑ Latex	❑ Other _____

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature:	Date:
Name of Emergency Contact:	Phone number & relationship to Patient: