DENTAL HEALTH HISTORY

Patient Name: _____ Birthdate:_____
Preferred Pharmacy: _____ Pharmacy Phone: _____

DENTAL HISTORY

Reason for Today's Visit: _____ Date of last cleaning:_____
Former Dentist: _____ Date of last dental x-rays: _____

Check (√) if you have had problems with any of the following:

□ Bad Breath	□ Grinding teeth/Jaw pain	□ Sensitivity
□ Bleeding gums	□ Loose teeth	□ Broken teeth/fillings
□ Clicking or popping jaw	□ Periodontal treatment	□ Sores/growths in mouth
□ Dry mouth	□ Food collection between teeth	□ Discolored teeth
□ Crowded teeth	□ Spaces between teeth	□ Missing teeth

How often do you floss? _____ How often do you brush? _____
Is there anything you would like to change about your smile? _____

MEDICAL HISTORY

Physician's Name _____ Date of last Visit _____
Have you had a serious illness or hospitalization in the past 5 years? □ YES □ NO
If yes, explain _____
Have you ever taken any bisphosphonate medications? □ YES □ NO
Are you taking any blood thinner medications? □ YES □ NO
Women: Are you pregnant? □ YES □ NO Nursing? □ YES □ NO
Do you use: Tobacco □ YES □ NO Type _____ Frequency _____
Alcohol □ YES □ NO Frequency_____
Other Drugs □ YES □ NO Type_____ Frequency _____

Check (√) if you have or have had any of the following:

□ Anemia	□ Cancer (Type _____)	□ Heart Attack	□ Liver Disease
□ Anxiety	□ Dementia	□ Heart Problems	□ Pacemaker
□ Arthritis	□ Depression	□ Heart Surgery	□ Respiratory Disease
□ Artificial Heart Valve	□ Diabetes	□ Hepatitis	□ Seizures
□ Artificial Joints	□ Fainting	□ High/Low Blood Pressure	□ Shortness of Breath
□ Asthma	□ GERD	□ HIV/AIDS	□ Stomach Ulcers
□ Bleed easily	□ Glaucoma	□ HPV	□ Stroke
□ Blood disorders	□ Headaches	□ Kidney Disease	□ Thyroid Problems
□ Other _____			□ Tuberculosis

MEDICATIONS

List medications you are currently taking:

_____
_____
_____
_____

ALLERGIES

□ Aspirin	□ Penicillin
□ Advil	□ Sulfa
□ Codeine	□ Latex
□ Local Anesthetic	□ Other _____
□ Other _____	□ Other _____

SOCIAL MEDIA RELEASE

I authorize Cumberland Pointe Dental to use the following on social media:

□ photographs of teeth/jaws only □ photographs of face □ feedback/written reviews □ first name

SIGNATURE

Patient/Guardian Signature_____ Date:_____