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DENTAL HISTORY:

Patient's Dentist: _____ Address: _____

Date of Last Dental Visit: _____

Any history of the following:

Yes	No	Removal of teeth	Yes	No	Sensitive teeth
Yes	No	Sore, bleeding gums	Yes	No	Gum treatment
Yes	No	Root canal work	Yes	No	Oral surgery

If "yes" to any of the above, please explain: _____

Yes	No	Grinds teeth at night	Yes	No	Clenches teeth at night
Yes	No	Breathes through mouth at night	Yes	No	Clicking or popping of jaws
Yes	No	Pain or aching of the lower jaw joint(s)			

If pain or ache of the lower jaw joint(s), please explain: _____

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MEDICAL HISTORY:

Patient's Physician: _____ Address: _____

Yes	No	Operations or injury to teeth or jaws	Yes	No	Joint problems
Yes	No	Severe headaches	Yes	No	Heart disease
Yes	No	Sinus trouble	Yes	No	Hepatitis
Yes	No	Frequent colds	Yes	No	Liver disorder
Yes	No	Persistent cough	Yes	No	Kidney disorder
Yes	No	Tonsillitis	Yes	No	Diabetes
Yes	No	Frequent sore throats	Yes	No	Endocrine disturbance
Yes	No	Deviated septum of the nose	Yes	No	Convulsions
Yes	No	Anemia	Yes	No	Venereal disease
Yes	No	Bleeding problems	Yes	No	Acquired immune deficiency
Yes	No	Tuberculosis	Yes	No	Speech problem
Yes	No	Rheumatic fever	Yes	No	Behavioral or emotional problems
Yes	No	High or low blood pressure			

Yes No Any other medical conditions we should be aware of? Describe: _____

_____

Yes No Allergies to any medicines or other substances (i.e. latex, metal)? Please list: _____

_____

Yes	No	Is patient in good health?	Yes	No	Any serious illnesses?
Yes	No	Any change in general health within the past year?	Yes	No	Is patient currently under a physician's care?
Yes	No	Has patient ever been hospitalized? For what reason: _____ _____	Yes	No	Has patient ever had surgery? Please describe: _____ _____
Yes	No	Have tonsils and/or adenoids been removed?	Yes	No	Sudden increase in height?
Yes	No	If a male, has patient started to shave?	Yes	No	If female, has patient started to menstruate?
Yes	No	Is your child's development within his/her age group? Earlier Later			

Please list any current medications you are currently taking and the reason for which you are taking them: _____

_____

_____

Signed: _____ Date: _____