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Dental History

Patient's Name: _____ Age: _____ Date: _____

If completing for someone other than yourself, please print your name and relationship to the patient:

Former Dentist: _____

Reason for today's visit: _____

Date of last exam: _____ Date of last dental X-rays: _____

How often do you brush? _____ How often do you floss? _____

Please check any of the following that apply to you at this time:

- | | | |
|---|---|--|
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Bleeding gums | <input type="checkbox"/> Broken teeth or fillings |
| <input type="checkbox"/> Loose teeth | <input type="checkbox"/> Periodontal treatment | <input type="checkbox"/> Dental fear |
| <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sore jaw muscles | <input type="checkbox"/> Clicking or popping jaw |
| <input type="checkbox"/> Sores or growths in your mouth | <input type="checkbox"/> Cold or heat sensitivity | <input type="checkbox"/> Take fluoride supplements |
| <input type="checkbox"/> Sweet sensitivity | <input type="checkbox"/> Pressure sensitivity | _____ |

Have you experienced breathing laughing gas (nitrous oxide) with your dental treatment?

Would you prefer using laughing gas (nitrous oxide) with your dental treatment?

Need to take antibiotics before dental treatment. Why? _____

Are you taking or have you taken Fosamax, Boniva, Actonel or other forms of bisphosphonate therapy?

Have experienced a reaction to penicillin, dental anesthetic or other.

Please specify and describe: _____

Emergency contact: _____ **Phone** _____ **Relationship** _____

Physician _____ **Phone** _____

MEDICAL HISTORY (Please circle if have or have had.)

<ul style="list-style-type: none"> • Hives, skin rash, Hay Fever • Any reaction to: <ul style="list-style-type: none"> Jewelry or metal Aspirin Penicillin, antibiotics, Sulfa Codeine or other narcotics Dental anesthetic Other medications Allergy to Latex • Arthritis • Asthma, Sinus trouble • Tumor or abnormal growth • Radiation treatment, chemotherapy • Any form of cancer _____ • Taking any medications regularly now or in the past year (list below or on back) _____ _____ 	<ul style="list-style-type: none"> • Emphysema • Stroke • Joint replacements • Type _____ Date _____ • Prolonged bleeding • Thyroid/Parathyroid disorder • Herpes, Venereal Disease, HPV • Kidney disease • Hepatitis, A B or C (Circle which) • Liver disease • Diabetes • Alcoholism • Epilepsy or seizures • Tuberculosis • Heart trouble If female are you now: • Pregnant • Taking oral contraceptives _____ 	<ul style="list-style-type: none"> • Rheumatic fever • Heart murmur • Arteriosclerosis • High blood pressure • Excessive swollen ankles • Chest pain • HIV positive • Pace maker, Artificial heart valve • Are you presently being treated for any illness? • Do you smoke? • Have you smoked in the past? • Do you use smokeless tobacco? • Are you taking or have taken Fosamax, Boniva, Actonel or other forms of bisphosphonate therapy? Other... _____
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SIGNATURE _____

DATE _____