PERSONAL HISTORY

Name_____Date_____
Last First Middle Initial

Address_____City_____Zip_____

Cell Phone_____HomePhone_____Email_____

Date of Birth_____Social Security #_____Marital Status_____

Occupation_____ Employer_____ Work Phone _____

Spouse's Name_____Cell Phone_____Employer_____

Dental Insurance Y or N Insurance Company_____Policy Holder Social Security #_____

Do you have a Secondary Dental Insurance? If so, Ins Name and Policy Holder _____

Name of relative or close friend _____Phone Number_____

Do we see any of your family members? If yes, please list names_____

DENTAL HISTORY

1. What concerns you most about your teeth?_____

2. Are you having discomfort now? YES or NO, if so explain._____

3. Do you have a fear of dentistry? YES or NO, if so why?_____

4. How long since you have been to the dentist? _____ What was done then? _____

5. Have you had orthodontic care (braces)? YES or NO

6. Have you ever had gum treatment? YES or NO If so, how long ago?_____

7. Have you ever lost or had teeth extracted? YES or NO If so, explain _____

8. Are your teeth sensitive to: Heat_____Cold_____Sweets_____Touch_____

9. Do you have any of the following: (indicate a "YES" with a checkmark)

___Sore gums ___Tendency to grind teeth ___Pain in jaw joint ___Problem with your bite ___Locking jaw

___Unpleasant taste ___Swelling or lump in mouth ___Frequent headaches ___Loose teeth ___Popping/clicking jaw

10. Are you completely happy with the appearance of your teeth? YES or NO

11. Do you feel your teeth will last a life time? YES or NO

12. Do you use a soft or hard brush?_____

13. How often do you brush your teeth? _____

14. Do you floss& how often? _____

NEWARK SMILES

GENERAL HEALTH HISTORY

Medical Doctor_____ **Medical Specialist** _____

15. Describe your general health: Good___ Fair ___ Poor ___

16. Are you under care of a physician now? YES or NO

17. Date of Last Exam _____ **If so, what for** _____

18. Do you smoke or use tobacco YES or NO If so, how many years? _____

19. Are you Pregnant? YES or NO

20. What medications (both prescription and over the counter) are you currently taking? _____

_____

21. Are you currently taking any blood thinners? If yes, why and name of medication _____

22. Please describe any current medical treatment, impending operations, or any other medical or dental information that may possibly affect your dental treatment: _____

_____

23. Do you require Pre-Medication before dental treatment? YES or NO If so, why?_____

24. Are you allergic to Latex? YES or NO

25. Do you have or have you ever had any of the following? (indicate a "YES" with a checkmark)

___ Any Heart Disease	___ Anemia	___Rheumatic Fever
___High Blood Pressure	___Arthritis	___Scarlet Fever
___Low Blood Pressure	___Diabetes	___Sinus Problems
___Mitral Valve Prolapse	___Latex Allergy	___Joint Replacement. If so, where& when_____
___Excessive Bleeding	___Kidney Problems	___Heart Attack or stroke. If so, when_____
___Glaucoma	___ Liver Disease	___Psychiatric Care
___Heart Murmurs	___Neurological problems	___Hepatitis
___Tuberculosis	___Epilepsy	___Radiation Treatments. If so, where_____
___Ulcer	___Lyme Disease	___Pace Maker. If so, when was it placed_____
___Jaundice	___HIV	___Cancer. If so, what type & when_____
___Tumors	___Venereal Disease	___Loss of hearing or eye sight?
___Asthma	___Dizziness	___Fainting

26. Do you have any allergies to: (indicate a "YES" with a checkmark)

___Aspirin	___Novocaine	___Dust, mold, food, etc. If so, list_____
___Penicillin	___Sulfa	___Other antibiotics. If so, list_____
___Codeine	___Local anesthetic	___Other medications. If so, list _____

Your Signature _____ **Today's Date** _____

Whom may we thank for referring to our office? _____