BRITE SMILES

Name _____

Date ____/____/____

DENTAL & MEDICAL HISTORY

Birthdate ____/____/____

Reason for today's visit _____ Date of last exam _____/_____/_____

How often do you brush? _____ Floss? _____ Mouthwash (type)? _____

Do you have any dental problems or history of an upsetting dental experience? ☐ Yes ☐ No

Describe _____

Have you ever had? ☐ Orthodontics ☐ Oral Surgery ☐ Periodontal Surgery

Please check any of the following conditions that apply to you:

☐ Bad breath	☐ Difficulty opening / closing	☐ Sensitivity to hot / cold / sweet
☐ Bleeding gums	☐ Loose teeth	☐ Sensitivity when biting
☐ Clicking / popping jaw	☐ Broken tooth / filling	☐ Dry mouth
☐ Food collection	☐ Periodontal treatment	☐ Grinding teeth / night guard
☐ Sore facial muscles	☐ Sores / growths in mouth	☐ Headaches or neck aches

☐ Other _____

Physician _____ Date of Last Visit _____/_____/_____

Current Medications and Reason For Taking _____

List all allergies _____

Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking Birth Control Pills? ☐ Yes ☐ No

Please indicate which of the following you have had or currently have: (Check all that apply)

☐ Anemia	☐ Chemical dependency	☐ Heart murmur / problems	☐ Pacemaker
☐ Anxiety	☐ Chemotherapy	☐ Hemophilia	☐ Rheumatic fever
☐ Arthritis	☐ Clotting disorder	☐ Hepatitis	☐ Sinus problems
☐ Artificial heart valves	☐ Cold sores	☐ High blood pressure	☐ Steroid treatments
☐ Asthma	☐ Diabetes Type I / II	☐ HIV/AIDS	☐ Stroke
☐ Back problems	☐ Epilepsy	☐ Joint replacement	☐ Thyroid problems
☐ Blood thinners	☐ Glaucoma	☐ Kidney trouble	☐ Tuberculosis
☐ Cancer	☐ Headaches		

☐ Other/Describe above _____

Do you smoke? ☐ Yes ☐ No Drink alcohol? ☐ Yes ☐ No Use recreational drugs? ☐ Yes ☐ No

Have you had surgery or been hospitalized in the last 10 years? ☐ Yes ☐ No Describe: _____

Patient Signature _____ **Date** ____/____/____