PerfectSmile Dental Practice

8735 Center Parkway, Suite #150 Sacramento, CA 95823 (916) 714-3410

Patient Name_____ **DOB:**_____ **Date:**_____

Dental History

Reason for today's visit _____

_____

Former Dentist _____

City/ State _____

Date of last dental visit _____

Date of last x-rays _____

Place a mark on "yes" or "no" to indicate if you had any of the following:

Bad breath	❑ Yes	❑ No
Bleeding gums	❑ Yes	❑ No
Blister on lips or mouth	❑ Yes	❑ No
Burning sensation on tongue	❑ Yes	❑ No
Clicking or popping jaw	❑ Yes	❑ No
Chew on one side of the mouth	❑ Yes	❑ No
Cigarette, pipe, or cigar Smoking	❑ Yes	❑ No
Dry mouth	❑ Yes	❑ No
Fingernail biting	❑ Yes	❑ No
Food collection between the teeth	❑ Yes	❑ No
Foreign objects	❑ Yes	❑ No
Grinding teeth	❑ Yes	❑ No
Gums swollen or tender	❑ Yes	❑ No
Jaw pain or tiredness	❑ Yes	❑ No
Lip or cheek biting	❑ Yes	❑ No
Mouth breathing	❑ Yes	❑ No
Mouth pain, brushing	❑ Yes	❑ No
Orthodontic treatment	❑ Yes	❑ No
Pain around ear	❑ Yes	❑ No
Periodontal treatment	❑ Yes	❑ No
Sensitivity to cold	❑ Yes	❑ No
Sensitivity to heat	❑ Yes	❑ No
Sensitivity to sweets	❑ Yes	❑ No
Sensitivity when biting	❑ Yes	❑ No
Sores or growths in your mouth	❑ Yes	❑ No

How often do you floss? _____

How often do you brush? _____

Health History

Physician's Name _____ Date of last visit _____

Are you now under the care of a physician? ❑ Yes ❑ No

If yes, please explain: _____

Have you ever had any complications following dental treatment? ❑ Yes ❑ No

If yes, please explain: _____

Have you been admitted to the hospital or needed emergency care during the past two years? ❑ Yes ❑ No

If yes, please explain: _____

Do you have any health problems that need further clarification? ❑ Yes ❑ No

If yes, please explain: _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" ❑ Yes ❑ No

These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).

_____

Have you ever experienced any of the following? Please examine each one and circle YES or NO:

Yes / No	AIDS/HIV	Yes / No	Glaucoma	Yes / No	Nervous Disorders	Yes / No	Tumors
Yes / No	Anemia	Yes / No	Growths	Yes / No	Pacemaker	Yes / No	Ulcers
Yes / No	Arthritis, Rheumatism	Yes / No	Hay Fever	Yes / No	Radiation Treatment	Yes / No	Venereal Disease
Yes / No	Artificial Joints	Yes / No	Head Injuries	Yes / No	Respiratory problems	Yes / No	Codeine Allergy
Yes / No	Asthma	Yes / No	Heart Disease	Yes / No	Rheumatic Fever	Yes / No	Penicillin Allergy
Yes / No	Blood Disease	Yes / No	Heart Murmur	Yes / No	Rheumatism	Yes / No	Osteoporosis
Yes / No	Cancer	Yes / No	Hepatitis	Yes / No	Sinus Problems		
Yes / No	Diabetes	Yes / No	High Blood Pressure	Yes / No	Stomach Problems	Medication:	
Yes / No	Dizziness	Yes / No	Jaundice	Yes / No	Stroke	_____	
Yes / No	Epilepsy	Yes / No	Kidney Disease	Yes / No	Tuberculosis		
Yes / No	Excessive Bleeding	Yes / No	Liver Disease	Yes / No	Pregnancy	Other :	
Yes / No	Fainting	Yes / No	Mental Disorders		Due Date: _____	_____	

Medications

List any medications you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy Name _____

Phone (_____)_____

Allergies

- ❑ Aspirin
- ❑ Barbiturates (Sleeping Pills)
- ❑ Codeine
- ❑ Iodine
- ❑ Latex
- ❑ Local Anesthetics
- ❑ Penicillin
- ❑ Sulfa
- ❑ Other _____

_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct.
If I ever have any change in my health, I will inform the doctors at the next appointment without fail. _____ **(Please Initial)**

Signature: _____