MOUNTAIN LOOP
DENTAL

Name _____

DOB _____

What is the reason for your dental visit today? _____

DENTAL HEALTH HISTORY

	Y	N
Do your gums bleed when you brush or floss?	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐
Is your mouth dry?	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐
Have you ever had orthodontic (braces) treament?	☐	☐
Have you had any problems associated with previous dental treatment?	☐	☐
Is your home water supply fluoridated?	☐	☐

	Y	N
Do you have earaches or neck pains?	☐	☐
Do you have any clicking, popping or discomfort in the jaw?	☐	☐
Do you brux or grind your jaw?	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐
Do you wear dentures or partials?	☐	☐
Have you ever had serious injury to your head or mouth?	☐	☐

MEDICAL HEALTH HISTORY

Are you under the care of a physician? Y ☐ N ☐ Physician name and phone number? _____

What condition is being treated? _____ Date of last physical exam? _____

Have you had a serious illness, operation, or been hospitalized in the last 5 years? Y ☐ N ☐

If yes, what was the problem? _____

Are you taking any prescription or over the counter medications? If so, please list: _____

	Y	N
Cardiovascular disease	☐	☐
Angina	☐	☐
Arteriosclerosis	☐	☐
Congestive heart failure	☐	☐
Damaged or replaced heart valves	☐	☐
Heart attack	☐	☐
Heart murmur	☐	☐
High or low blood pressure	☐	☐
Other congenital heart defects	☐	☐
Mitral valve prolapse	☐	☐
Pacemaker	☐	☐
Rheumatic fever	☐	☐
Rheumatic heart disease	☐	☐
Abnormal bleeding	☐	☐
Anemia	☐	☐
Blood transfusion	☐	☐

	Y	N
AIDS or HIV infection	☐	☐
Arthritis	☐	☐
Rheumatoid arthritis	☐	☐
Autoimmune disease	☐	☐
Asthma	☐	☐
Bronchitis	☐	☐
Emphysema	☐	☐
Sinus problems	☐	☐
Tuberculosis	☐	☐
Cancer or tumor	☐	☐
Chronic pain	☐	☐
Chemotherapy	☐	☐
Radiation	☐	☐
Diabetes	☐	☐
Gastrointestinal problems	☐	☐
Glaucoma	☐	☐

	Y	N
GERD	☐	☐
Ulcers	☐	☐
Thyroid problems	☐	☐
Stroke	☐	☐
Hepatitis jaundice or liver disease	☐	☐
Epilepsy	☐	☐
Fainting or seizures	☐	☐
Neurological disorder	☐	☐
Mental health disorder	☐	☐
Recurrent infections	☐	☐
Kidney problems	☐	☐
Osteoporosis	☐	☐
Headaches or migraines	☐	☐
Severe or rapid weight loss	☐	☐
Sexually transmitted disease	☐	☐
History of drug or alcohol abuse	☐	☐

Do you have any other condition or problem not listed? Y ☐ N ☐ If so what? _____

Tobacco use? Y ☐ N ☐ If so how much and for how long? _____

Do you drink alcoholic beverages? Y ☐ N ☐ If so how much do you typically drink in a week? _____

Do you use controlled substances (drugs)? Y ☐ N ☐

Has a physician or previous dentist recommended that you take antibiotics prior to dental treatment? Y ☐ N ☐

Women only

Are you taking contraceptives or other hormones? Y ☐ N ☐

Are you or could you be pregnant? Y ☐ N ☐ If so, expected delivery date _____ Are you nursing? Y ☐ N ☐

Are you allergic, or have you reacted adversely, to any of the following?

	Y	N
Local anesthetics ("Novocaine")	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐
Aspirin, Acetaminophen, or Ibuprofen	☐	☐

	Y	N
Codeine, Demerol, or other narcotics	☐	☐
Reaction to metals	☐	☐
Latex or rubber dam	☐	☐

Other _____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize Dr. Gore and/or dental staff to perform all necessary dental services that I may need. I understand that I am responsible for payment of services rendered and also responsible for paying any unpaid portion that my insurance does not cover.

Signature _____ Date _____

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