BeGentle Dentistry

Dental History

What would you like us to do today? ___________________________________ Are you in dental discomfort today? _______

Previous Dentist: ____ Date of last dental care: _______________________

Circle if you have had problem with any of the following:

bad breath	food collection between teeth	periodontal treatment	sensitivity to sweets
bleeding gums	grinding or clenching	sensitivity to cold	sensitivity when biting
sores in mouth	clicking or popping in jaw	sensitivity to hot	loose teeth or broken fillings

How often do you brush? ____________________________ How often do you floss? __________________________________

How do you feel about the appearance of your teeth? ____

Other information about your dental health or previous treatment? ____

Medical History

Physician's Name: ____ Phone: ____________________

Have you had any serious illnesses or operations? **YES NO** If yes, describe:

____

Are you currently under physician care? **YES NO** If yes, describe:

____

Has patient had any recent heart conditions within the last 6 months? **YES NO** If yes, please describe:

____

Does patient have any artificial joint replacements? **YES NO** If yes, please describe. Does your physician require an antibiotic before dental procedures for your artificial joint?

____

____

Have you ever used a bisphosphonate medication? (Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva) **YES NO**

Women: Are you pregnant? **YES NO** Nursing? **YES NO** Taking birth control? **YES NO**

PLEASE COMPLETE OTHER SIDE →

Circle **YES** or **NO** whether you have had any of the following:

YES NO AIDS/HIV Positive	YES NO Jaw Pain	YES NO Radiation Treatment
YES NO Anaphylaxis	YES NO Kidney Disease	YES NO Respiratory disease
YES NO Anemia	YES NO Liver Disease	YES NO Rheumatic/Scarlet fever
YES NO Arthritis/Rheumatism	YES NO Latex Allergy	YES NO Shingles
YES NO Artificial heart valves	YES NO Mitral valve prolapse	YES NO Shortness of breath
YES NO Asthma	YES NO Heart Murmur	YES NO Spina Bifida
YES NO Blood Disease	YES NO Heart Problems	YES NO Stroke
YES NO Cancer	Describe: ________________	YES NO Surgical implant
YES NO Chemical Dependency	YES NO Hemophilia	YES NO Swelling of feet or ankles
YES NO Chemotherapy	YES NO Herpes	YES NO Thyroid disease
YES NO Circulatory Problems	YES NO Hepatitis	YES NO Tobacco habit
YES NO Cortisone Treatments	YES NO High blood pressure	YES NO Tuberculosis
YES NO Diabetes	YES NO Nervous Problems	YES NO Ulcer/Colitis
YES NO Epilepsy	YES NO Pacemaker	YES NO Venereal disease
YES NO Food Allergies	YES NO Heart Surgery	
YES NO Glaucoma	YES NO Psychiatric care	
YES NO Headaches		

Is patient currently taking **ANY** blood thinner medication? If yes, which one? ____

Is patient currently taking any medications? If yes, list all:

____
____
____
____
____
____

Does patient have drug allergies? If yes, list all:

____
____
____
____
____
____

Preferred pharmacy location (please state store & city): ____

Preferred dentist (Please circle one): Dr. Edward Mamaril Dr. Allison Gibson Dr. David Sturgeon I don't have a preference

Preferred hygienist: ________________________________ OR I don't have a preference

Signature: ____ Date: ____________________