Kennesaw Dental Excellence

Dental Health History

(Please Print)

Patient First Name　　　　Patient Last Name　　　　Date

Please check Yes or No for those that apply to you.

YES	NO	
☐	☐	Sensitivity to: Hot Cold Sweet
☐	☐	Chipped / Broken Teeth
☐	☐	Crooked or Tipped Teeth
☐	☐	Loose Teeth
☐	☐	Missing or Spaces Between Teeth
☐	☐	Catch Food Between Teeth
☐	☐	Dry Mouth or Constantly Thirsty
☐	☐	Smoke or Use Chewing Tobacco

YES	NO	
☐	☐	Bleeding, Swollen or Irritated Gums
☐	☐	Dissatisfied With Appearance of My Teeth
☐	☐	Frequent Headaches
☐	☐	Jaw Joint Pain
☐	☐	Grinding or Clenching Teeth
☐	☐	Uncomfortable or Uneven When I Bite My Teeth Together
☐	☐	Clicking or Popping of Jaw
☐	☐	Difficulty Opening or Chewing

Please check Yes or No if you have, or have had any of the following?

YES	NO	
☐	☐	Dentures or Partials
☐	☐	Braces or Clear Braces
☐	☐	Periodontal Disease or Gum Treatments
☐	☐	Fixed Bridge
☐	☐	Dental Implants
☐	☐	Crowns

YES	NO	
☐	☐	Veneers
☐	☐	Jaw Surgery
☐	☐	Root Canals
☐	☐	Sleep Apnea
☐	☐	C-PAP Machine or Oral Sleep Appliance
☐	☐	Fear or Anxiety About Dental Treatment

If I could change my smile, I would:

☐ Make My Teeth Whiter
☐ Make My Teeth Straighter
☐ Close Spaces or Gaps That Bother Me
☐ Replace Dark Metal Fillings With Tooth Colored Fillings
☐ Fix My Teeth So I'm Not Embarrassed When I Smile
☐ Repair Chipped Teeth
☐ Replace Missing Teeth
☐ Replace Old Crowns That Look Dark or Don't Match
☐ Have a Smile Makeover
☐ Stop My Jaw From Hurting or Clicking

On a scale of 1 – 10, with 10 being the highest rating:

How important is your dental health to you? 1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health? 1 2 3 4 5 6 7 8 9 10

Tell me about my options for replacing missing teeth with Dental Implants? ☐ Yes ☐ No
Tell me how I can straighten my teeth in 6 months instead of 2 years and if I'm a candidate? ☐ Yes ☐ No
Have you ever been sedated for dental treatment? ☐ Yes ☐ No
Are you interested in sedation options? ☐ Yes ☐ No
If you could whiten your teeth for a investment anyone could afford, would you be interested? ☐ Yes ☐ No

If this is your first time in our office please answer the following:

Date of last cleaning? ___ / ___ Date of last oral cancer screening? ___ / ___ Date of last complete x-rays? ___ / ___

What is the most important thing to you about your dental visit today: ______________________

Why did you leave your previous dentist? ______________________

Kennesaw Dental Excellence

Medical Health History

(Please Print)

Patient First Name   Patient Last Name   Date

Address   Email   Phone

Please check Yes or No for those that apply to you.

YES NO
☐ ☐ Anemia
☐ ☐ Arthritis
☐ ☐ Artificial Heart Valve
☐ ☐ Artificial Joints
☐ ☐ Asthma
☐ ☐ Blood Disease
☐ ☐ Bruise Easily
☐ ☐ Cancer
☐ ☐ Chemotherapy
☐ ☐ Diabetes
☐ ☐ Dizziness

YES NO
☐ ☐ Emphysema
☐ ☐ Excessive Bleeding
☐ ☐ Fainting
☐ ☐ Glaucoma
☐ ☐ Heart Conditions
☐ ☐ Heart Lesions
☐ ☐ Heart Murmur
☐ ☐ Heart Surgery
☐ ☐ Hepatitis: A B C
☐ ☐ High Blood Pressure
☐ ☐ HIV Positive
☐ ☐ Jaundice

YES NO
☐ ☐ Kidney Disease
☐ ☐ Liver Disease
☐ ☐ Low Blood Pressure
☐ ☐ Mitral Valve Prolapse
☐ ☐ Nervousness / Depression
☐ ☐ Pacemaker
☐ ☐ Periodontal Disease
☐ ☐ Radiation (Head / Neck)
☐ ☐ Respiratory Problems
☐ ☐ Rheumatic Fever
☐ ☐ Rheumatism

YES NO
☐ ☐ Seizures
☐ ☐ Stomach Problems
☐ ☐ Stroke
☐ ☐ Thyroid Disease
☐ ☐ Tuberculosis
☐ ☐ Ulcers
☐ ☐ Venereal Disease

Women Only
☐ ☐ *Birth Control*
☐ ☐ *Nursing*
☐ ☐ *Pregnant*: Delivery Date:

Do you have any of the following drug allergies?

YES NO
☐ ☐ Aspirin
☐ ☐ Codeine
☐ ☐ Darvon
☐ ☐ Erythromycin

YES NO
☐ ☐ Latex
☐ ☐ Anesthetic
☐ ☐ Nitrous Oxide
☐ ☐ Sulfa

YES NO
☐ ☐ Percodan
☐ ☐ Penicillin
☐ ☐ Antibiotics
☐ ☐ Other

Please list other allergies.
____
____
____

Please check any of the following drugs you have used at any time:

YES NO
☐ ☐ Fosamax
☐ ☐ Aredia

YES NO
☐ ☐ Didronel
☐ ☐ Actonel

YES NO
☐ ☐ Zometa
☐ ☐ Skelid

YES NO
☐ ☐ Boniva
☐ ☐ Bisphosphonates

List ALL medications you currently take. (Prescription & Over The Counter. Attach List if Needed)

____________ ____________ ____________ ____________
____________ ____________ ____________ ____________

Using The Epworth Sleepiness Scale of 0 – 3 How likely are you to doze off or fall asleep in the following situations?
No chance of dozing = 0 Slight chance of dozing = 1 Moderate chance of dozing = 2 High chance of dozing = 3

__ Sitting and Reading
__ Watching TV
__ Sitting inactive in a public place, ie... theater or a meeting
__ As a passenger in a car for an hour without a break
__ Lying down to rest in the afternoon if conditions permit
__ Sitting and talking to someone
__ Sitting quietly after lunch without alcohol
__ In a car, while stopped for a few minutes in traffic
__ **TOTAL SCORE**

If under physicians care please explain?______________________
____
Physician's Name: ______________________
Physician's Phone: ______________________

I certify the information recorded on this medical & dental form is correct. I understand it is my responsibility to notify PRACTICE NAME HERE of any changes. I understand if I withhold information regarding allergies, medical conditions, medications, or supplements; I agree not to hold PRACTICE NAME HERE or its employees liable in the event of death or injury.

Signature (Patient / Guardian) ______________________ Date: __________ Dentist Signature: ______________