REED FAMILY DENTAL

New Patient Health History

Patient Name ________________________________ Birthdate ___________________

Dental History

Reason for today's visit ____

Former dentist ____

Address ____

Date of last dental x-rays ________________ Date of last dental care ______________

Mark an (x) if you had issues with any of the following:

__ Bad breath
__ Bleeding gums
__ Clicking/popping jaw
__ Food collection between teeth
__ Grinding teeth
__ Loose/broken teeth
__ Gum treatment
__ Tooth sensitivity
__ Sores in your mouth
__ Dry mouth
__ Swelling
__ Pain when biting

Medical History

Physician's Name____________________________________ Date of last visit ________

Mark an (x) if you have or have had any of the following:

__ Anemia
__ Arthritis
__Artificial heart valves
__Artificial joints
__Asthma
__Back problems
__Blood disorder
__Cancer
__Chemical dependency
__Chemotherapy
__Circulatory problems
__COPD
__ Diabetes
__ Epilepsy
__ Fainting
__ Glaucoma
__ Heart issues
__ Heart stent
__ Hepatitis (Type __)
__ High blood pressure
__ High cholesterol
__ HIV/AIDS
__ Kidney disease
__ Liver disease
__ Pacemaker
__ Radiation therapy
__ Respiratory problems
__ Rheumatic fever
__ Shortness of breath
__ Stroke
__ Thyroid problems
__ Tobacco use
__ Tuberculosis
__ Ulcers
__ Venereal disease

Pregnant/breastfeeding? Yes _____ No _____

Pre-med: Yes ______ No ______ If so, please list. ___________________________________

Allergies ____

Medications ____

____

____

Major surgeries and dates ____

The above information is accurate to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature ______________________________________ Date _____________________