PLANNED CARE HEALTH RECORD

It is important to tell all dental personnel involved in your treatment about the general state of your health. This information is, of course, confidential.

Name _____ Date of Birth _____

DENTAL HISTORY

1. Former dentist _____ Address _____
2. When did you last visit a dentist? _____ X-rays taken? Yes ☐ No ☐
   What was done at that time? _____
   Why did you leave that practice? _____
   Did you make regular visits to the dentist before then? Yes ☐ No ☐
3. Are you aware of a dental problem? Yes ☐ No ☐ Explain _____
4. What do you feel is the present condition of your mouth? _____
5. Do your gums bleed? Yes ☐ No ☐
6. Have you ever been told you have gum disease? Yes ☐ No ☐
7. Does food chronically collect between your teeth? Yes ☐ No ☐
8. Are your teeth acutely sensitive to: Sweet ☐ Cold ☐ Heat ☐ Pressure ☐ No ☐
9. How often do you brush your teeth? _____
10. How often do you floss your teeth? _____
11. Are you interested in preventing further dental problems by having regular dental exams and care? Yes ☐ No ☐
12. Anything else that would be valuable for me to know? _____
13. Has any dental treatment been recommended to you that you have not had done? _____
14. Are you happy with the appearance of your smile? Yes ☐ No ☐ Explain _____
15. Do you like the color of your teeth? Yes ☐ No ☐
16. Are there old fillings or dental work that you don't like looking at? Yes ☐ No ☐
17. What would you like to change the most in the appearance of your teeth? _____
18. Do you vape or use any tobacco products? ☐ Yes ☐ No Explain _____

MEDICAL HISTORY

1. Name and address of physician _____
2. When was your last physical examination? _____
3. Are you now under the care of a physician? Yes ☐ No ☐
   If yes, for what reason? _____

(OVER, PLEASE)

4. Are you presently taking any medications/drugs/pills? Yes ☐ No ☐ Please list:

5. Do you use any recreational drugs? Yes ☐ No ☐ If yes, how long? ____

5. (Women) Are you pregnant? Yes ☐ No ☐ If yes, how long? ____

6. Are you allergic to: Penicillin ☐ Codeine ☐ Local Anesthetic ☐ None ☐

Other ☐ ____

7. Do you have, or have you ever had:

Heart trouble	Yes ☐	No ☐	Excessive or prolonged bleeding	Yes ☐	No ☐
Heart murmur	Yes ☐	No ☐	Fainting spells	Yes ☐	No ☐
Heart surgery	Yes ☐	No ☐	Jaundice	Yes ☐	No ☐
Heart pacemaker	Yes ☐	No ☐	Hepatitis - Type: ____	Yes ☐	No ☐
Rheumatic fever	Yes ☐	No ☐	Asthma	Yes ☐	No ☐
Congenital heart defects	Yes ☐	No ☐	Sinus trouble	Yes ☐	No ☐
Abnormal blood pressure	Yes ☐	No ☐	Cancer	Yes ☐	No ☐
Ulcers	Yes ☐	No ☐	Chemotherapy/radiation	Yes ☐	No ☐
Tuberculosis or lung disease	Yes ☐	No ☐	Stroke	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	Glaucoma	Yes ☐	No ☐
Epilepsy	Yes ☐	No ☐	Psychiatric care	Yes ☐	No ☐
Anemia	Yes ☐	No ☐	Prosthetic implant	Yes ☐	No ☐
Thyroid problem	Yes ☐	No ☐	Artifical Joint Replacements	Yes ☐	No ☐
Chemical dependency	Yes ☐	No ☐	Venereal disease	Yes ☐	No ☐
Arthritis	Yes ☐	No ☐	HIV positive/AIDS	Yes ☐	No ☐

8. Have you had any other serious illness, hospitalization or accident? Yes ☐ No ☐

If yes, please explain ____

I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. This information on this page is correct to the best of my knowledge.

Patient Signature ____ Date ____
(PARENT OR GUARDIAN)

Recorded by ____ D.D.S. Signature ____

UPDATE Patient Signature ____ D.D.S. Signature ____	UPDATE Patient Signature ____ D.D.S. Signature ____
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