*Cosmetic and Family Dentistry*
*Bradley H. Reiner, D.M.D., F.A.G.D.*
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**PATIENT NAME: _____ DOB:_____**

**DENTAL HISTORY**

Last Dental visit _____ Date of last cleaning_____
Why have you come to see us today?_____
What problems have you had with past dental treatment?_____
Are you nervous about seeing the dentist? □Y □N If yes, please tell us why:_____
How often do you brush and floss?_____

**Please check those that apply to you:**

□ Clench or grind teeth
□ Clicking or popping in jaw
□ Difficulty opening or closing
□ Gums bleed while brushing
□ Swollen Gums
□ I had orthodontics
□ I have problems eating
□ Facial or jaw injury

**HEALTH HISTORY**

Are you currently under a physician's care? **Y** □ **N** □
If yes, please describe: _____
Primary Physician's Name _____ Physician's Phone_____
Have you had a serious illness or operation in the past 5 years? **Y** □ **N** □
If yes, please describe: _____

**Please check those conditions that have ever applied to you:**

**CONDITIONS:**

□ Abnormal bleeding
□ Anemia
□ Angina
□ Arthritis
□ **Artificial Heart Valve**
□ Asthma
□ **Bisphosponate Treatment**
□ Blood Transfusion
□ Cancer
□ Chemotherapy
□ **Congenital Heart Defect**
□ COPD/ Emphysema
□ Diabetes
□ Drug or Alcohol Abuse
□ Epilepsy
□ Facial Surgery
□ Glaucoma
□ HIV/ AIDS
□ **Heart Attack**
□ **Joint Replacement**
□ Heart Murmur
□ Heart Surgery
□ Hemophilia
□ Hepatitis A, B, or C
□ High/Low Blood Pressure
□ Kidney Problems
□ Liver Disease
□ Mitral Valve Prolapse
□ Pacemaker
□ Radiation Therapy
□ Rheumatic Fever
□ Seizure
□ Sexually Transmitted Disease
□ Shingles
□ Sickle Cell Anemia
□ Sinus Problems
□ Stomach Problems
□ **Stroke**
□ Thyroid Problems
□ Tobacco Use
□ Tuberculosis
□ Ulcers

**ALLERGIES:**

□ Aspirin
□ Codeine
□ Erythromycin
□ Ibuprofen
□ Latex, Metals, Plastics
□ Local Anesthetic
□ Penicillin
□ Sulfa Drugs
□ Morphine
□ Other Medications

**Please list any medications you are currently taking:**

□ **Anticoagulants** □ **Cortisone** □ **Antibiotics** □ **Tranquilizers** □ **Nitroglycerin** □ **Bisphosphonates**

_____
_____
_____

**WOMEN ONLY:**

**Y** □ **N** □ Are you taking Birth Control Pills? **Y** □ **N** □ Are you nursing?
**Y** □ **N** □ Are you pregnant? (If yes, # weeks _____)

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

_____ _____
Patient or Parent/Guardian Signature Date