CAREDENTAL

NEW PATIENT

Name: ______________________________ **Date of Birth**: _______/________/_________
MM DD YYYY

Occupation: ____

Are there any areas in your mouth hurting you? YES or NO If yes, please specify: ________________________________

Do you have a specific concern you want the doctor to address first? ____

How long has this been a problem? ____

How many years since your last dental visit? ____________ How many years since your last hygiene (cleaning)? ____________

Is there anything you would like to change about your smile? ____

Please **CIRCLE** any services that may interest to you:

Orthodontics (Braces/Invisalign) Whitening Veneers Implants Dentures

MEDICAL QUESTIONS

Have you had any health problems in the past five (5) years? ____

Have you seen a physician or health care provider in the past two (2) years? YES or NO

Current Physicians' name: ___________________________________ Phone # or City: ______________________________

Have you ever had surgery or hospital visit? YES or NO If yes, please specify: _____________________________________

Have you been advised to take antibiotics before dental appointments? YES or NO

Do you use tobacco products? YES or NO If yes, please specify type and amount per day:____________________________

Any other MEDICAL condition you think we should be aware of? ____

Please list ALL medications/multi-vitamins/supplements you are CURRENTLY taking and why you take them:

Medication	**Reason for Use**	**Medication**	**Reason for Use**
1.		**6.**	
2.		**7.**	
3.		**8.**	
4.		**9.**	
5.		**10.**	

OFFICE USE ONLY	BP: mmHg	PULSE:

Name: ____________________________ **PLEASE <u>CHECK</u> ALL THAT APPLY**

HEART/BLOOD
- ☐ Congenital Heart Disease
- ☐ Rheumatic Fever
- ☐ Irregular or rapid heartbeat
- ☐ High Blood Pressure
- ☐ Chest Pain
- ☐ Heart Attack
- ☐ Stroke
- ☐ Endocarditis
- ☐ Joint replacement
- ☐ Problem with heart valve
- ☐ Artificial heart valve
- ☐ Pacemaker
- ☐ Heart Transplant
- ☐ Blood clots or thrombosis
- ☐ Anemia
- ☐ Sickle cell disease or trait
- ☐ Hemophilia
- ☐ Transfusion
- ☐ Other heart, vessel or blood disorder: ________________________________

HEAD & NECK
- ☐ Frequent or severe nosebleeds
- ☐ Difficulty swallowing
- ☐ Glaucoma
- ☐ Headaches
- ☐ Sinusitis
- ☐ Injuries to head, neck, jaw or teeth: ________________________________
- ☐ Other: __________________________

MUSCLES/BONES
- ☐ Sjogren's Syndrome
- ☐ Arthritis
- ☐ Chronic Back Pain
- ☐ Other: ___________________________

URINARY TRACT
- ☐ Kidney Disease
- ☐ Renal Disease
- ☐ STD
- ☐ Other: __________________________

DIGESTIVE SYSTEM
- ☐ Liver Disease
- ☐ Ulcers
- ☐ Jaundice
- ☐ Frequent heartburn
- ☐ Other: ___________________________

RESPIRATORY
- ☐ Tuberculosis (TB)
- ☐ Asthma
- ☐ Bronchitis
- ☐ Persistent Cough
- ☐ Shortness of Breath
- ☐ Other: _________________________

ENDOCRINE
- ☐ Low thyroid
- ☐ Cushings Syndrome
- ☐ Parathyroid condition
- ☐ Diabetes
- ☐ Other: __________________________

NERVES
- ☐ Epilepsy
- ☐ Seizures
- ☐ Multiple Sclerosis (MS)
- ☐ Trigeminal Neuralgia
- ☐ Chronic Pain
- ☐ Other: __________________________

MENTAL HEALTH
- ☐ Anxiety
- ☐ Depression
- ☐ Psychiatric treatment or counselling
- ☐ Other: ___________________________

CANCER
- ☐ Leukemia
- ☐ Benign tumors/growths
- ☐ Other: ___________________________
- ☐ Treatment: _______________________

ALLERGIES

Allergic reaction or bad reaction to:
- ☐ Dental anesthetics
- ☐ Penicillin
- ☐ Sulfa drugs
- ☐ Antibiotics
- ☐ Aspirin
- ☐ Latex
- ☐ Metals
- ☐ Other:__________________________

FAMILY HISTORY

Has anyone in your immediate family ever had:
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Tuberculosis (TB)
- ☐ Depression
- ☐ Other: __________________________

OTHER
- ☐ HIV
- ☐ Organ Transplant
- ☐ Methamphetamine
- ☐ IV Drugs
- ☐ Herpes simplex (cold sores)
- ☐ Hepatitis A B C

WOMEN

Are you or is there a possibility that you may be pregnant?

YES or NO

Any form of birth control?

YES or NO

Initial please: ____________

Name: ___________________________________

Please **CHECK** any of the following symptoms you may have:

HEAD AND FACE

- ☐ Pain in forehead
- ☐ Pain in temporal area
- ☐ Tension headaches
- ☐ Migraine headaches
- ☐ Sinus headaches
- ☐ Back of head headaches
- ☐ Hair, scalp tender to touch

NASAL

- ☐ Sinus pain
- ☐ Sinus problems
- ☐ Post nasal drainage
- ☐ Allergies

EYES

- ☐ Pain in/around eyes
- ☐ Bloodshot eyes
- ☐ Sensitive to light
- ☐ Tearing of eyes
- ☐ Blurred vision
- ☐ Pressure behind eye

EARS

- ☐ Ear pain without infection
- ☐ Decreased hearing
- ☐ Clogged, itchy or stuffy
- ☐ Ringing or buzzing
- ☐ Dizziness
- ☐ Balance problems

NECK

- ☐ Lack of mobility
- ☐ Stiffness
- ☐ Neck pain
- ☐ Tired or sore neck muscles
- ☐ Shoulder pain
- ☐ Back pain: middle, lower
- ☐ Arm or finger pain/numbness

THROAT

- ☐ Swallowing difficulties
- ☐ Feeling of foreign object in throat
- ☐ Sore throat without infection
- ☐ Voice changes
- ☐ Laryngitis
- ☐ Frequent coughing or clearing

MOUTH

- ☐ Abnormal opening
- ☐ Limited opening
- ☐ Bad bite
- ☐ Missing teeth
- ☐ Excessive mouth breathing
- ☐ Clench or grind teeth
- ☐ Mouth discomfort
- ☐ Inability to find "bite"

JAW (TMJ)

- ☐ Jaw pain
- ☐ Jaw joint pain
- ☐ Clicking or popping of jaw joint
- ☐ Grating sounds in jaw joint
- ☐ Pain in cheek muscles
- ☐ Uncontrollable jaw movements
- ☐ Jaw locks open/shut
- ☐ Deviates to one side on opening or closing

Date: ___________________________________

Signature:________________________________