



Patient Name: \_\_\_\_\_

	<i>YES</i>	<i>NO</i>
Diabetes	_____	_____
Radiation Treatments	_____	_____
Epilepsy	_____	_____
Kidney Problems	_____	_____
Nervous Problems	_____	_____
Tuberculosis	_____	_____
Excessive Bleeding	_____	_____
Cerebral Palsy	_____	_____
Scarlet Fever	_____	_____
Malignancies/Cancers	_____	_____
Chronic Sinus	_____	_____
Chronic Ear Problems	_____	_____
Anemia	_____	_____
Arthritis	_____	_____
Adenoids removed	_____	_____
Tonsils removed	_____	_____
Asthma	_____	_____

Name of Previous Dentist: \_\_\_\_\_ City/State: \_\_\_\_\_

Date of last visit: \_\_\_\_\_ Reason for last visit: \_\_\_\_\_

Are you sensitive to: Heat: \_\_\_\_\_ Cold: \_\_\_\_\_ Sweets: \_\_\_\_\_ Chewing/Pressure: \_\_\_\_\_

Have you had any injuries to the mouth/jaw area? \_\_\_\_\_

When were your last dental x-rays? \_\_\_\_\_ When was your last cleaning and exam? \_\_\_\_\_

Do your gums bleed or feel tender or irritated? Yes: \_\_\_\_\_ No: \_\_\_\_\_

Have you ever had periodontal treatments/surgery? Yes: \_\_\_\_\_ No: \_\_\_\_\_

If Yes, please explain: \_\_\_\_\_

Do you smoke or use tobacco products? Yes: \_\_\_\_\_ No: \_\_\_\_\_

Do you wear dentures/partials? Yes: \_\_\_\_\_ No: \_\_\_\_\_

Are you aware of grinding or clenching your teeth? Yes: \_\_\_\_\_ No: \_\_\_\_\_

Do you have discolored teeth that bother you? Yes: \_\_\_\_\_ No: \_\_\_\_\_

Are there any dental concerns you would like Dr. Morris to be aware of: \_\_\_\_\_

***I hereby acknowledge that I have provided the above health information to Dr. Sarah Morris and that it is true and accurate.***

\_\_\_\_\_  
Patient Signature or Guardian

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date