SUMMIT
DENTAL HEALTH

Patient Name _____ Date _____

Dental History

Please check any of the following that apply to you:

- ❑ Sensitivity (hot, cold, sweets, pressure)
- ❑ Discomfort when chewing
- ❑ Headaches, ear aches, neck pain
- ❑ Jaw joint pain
- ❑ Teeth or fillings breaking
- ❑ Grinding or clenching teeth
- ❑ Bleeding, swollen or irritated gums
- ❑ Loose, chipped or shifting your mouth
- ❑ Bad breath or bad taste in your mouth

Do you have or have you ever had any of the following?

- ❑ Dentures
- ❑ Partial Dentures
- ❑ Braces
- ❑ Periodontal (gum) treatments

What is the most important thing about your visit today?

_____

What would you like to do to improve your smile?

- ❑ Whiten
- ❑ Straighten
- ❑ Close spaces
- ❑ Replace silver fillings with tooth colored fillings
- ❑ Repair chipped teeth
- ❑ Replace missing teeth
- ❑ Replace old crowns that don't match other teeth

_____
Name of previous dentist

_____
City & State

_____
Phone number

Medical History

- ❑ AIDS/HIV positive
- ❑ Anemia
- ❑ Arthritis
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Blood Disease
- ❑ Blood Thinner
- ❑ Cancer
- ❑ Diabetes ❍ Type 1 ❍ Type 2
- ❑ Dizziness
- ❑ Epilepsy
- ❑ Excessive Bleeding
- ❑ Fainting
- ❑ Glaucoma
- ❑ Head Injuries
- ❑ Heart Disease
- ❑ Heart Murmur/Mitro Valve Prolapse
- ❑ Hepatitis A B C
- ❑ High Blood Pressure
- ❑ Jaundice
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Mental Disorders
- ❑ Nervousness/Depression
- ❑ Pacemaker
- ❑ Pregnant (currently)
  due date _____
- ❑ Radiation Treatment
- ❑ Repiratory Problems
- ❑ Sinus Problems
- ❑ Stent
- ❑ Stomach Problems
- ❑ Stroke
- ❑ Tobacco User (currently)
- ❑ Tuberculosis
- ❑ Tumors
- ❑ Other _____

Please list any medications that you take:

_____
_____
_____
_____
_____
_____
_____

Are you taking any osteoporosis medications?
❑ Yes ❑ No
If yes, please list medications:

_____
_____

Do you have any allergies?
❑ Yes ❑ No
If yes, please list all allergies:

_____
_____

Sedation Only

- ❑ Grapefruit Juice
- ❑ Antipsycotics
- ❑ Saint Johns Wart
- ❑ Dilatin / Verapamil
- ❑ "navirs"
- ❑ Antifungals
- ❑ Prilosec / Nexium
- ❑ Tagament
- ❑ Doxycycline / Biaxin

Family Doctor _____ Phone Number _____

Patient/Parent Signature _____ Date _____

Doctor Signature _____ Date _____