PATIENT INFORMATION AND HEALTH HISTORY
MIAMI LAKES OFFICE OF COSMETIC AND RECONSTRUCTIVE DENTISTRY

Today's Date___________________

Patient's Name____Date of Birth___________________

Single Married Divorced Seperated Widowed

Mailing Address____City_____________Zip Code_______________

Phone Home__________________________Business_____________________________Cell_______________________________________

Person Responsible for Account____Patient's SS#_______________________________

Employed by____Dental Insurance Plan________________________________

Insured's Name _______________________________Date of Birth _________________________Insured's SS#______________________

You were Referred by _____________________________________Your Email____

DENTAL HISTORY

CHIEF ORAL COMPLAINT____

DATE OF LAST DENTAL EXAM____________________PREVIOUS DENTAL OFFICE____

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING—INDICATE WITH A ☑

- ☐ **Teeth sensitive to cold, heat, sweets or pressure**
- ☐ **Bleeding gums. How long_____________**
- ☐ **Food impaction**
- ☐ **Clenching or grinding**
- ☐ **Burning of tongue**
- ☐ **Swelling or lumps in mouth**
- ☐ **Frequent blisters on lips or mouth**
- ☐ **Pain around ear or joint sounds**
- ☐ **Bad breath**
- ☐ **Unpleasant taste**
- ☐ **Unfavorable dental experience**
- ☐ **Complications from extractions**
- ☐ **Periodontal treatment**
- ☐ **Orthodontic treatment**
- ☐ **Mouth breathing**
- ☐ **Oral habits-fingernail biting etc.**
- ☐ **Cigarettes, pipe or chewing tobacco**
- ☐ **Texture of toothbrush_____________**
- ☐ **Frequency of brushing_____________**
- ☐ **Dental floss**
- ☐ **Inter dental stimulators**
- ☐ **Water jet device**
- ☐ **disclosing tablets**
- ☐ **Fluoride supplements**

MEDICAL HISTORY

PHYSICIANS'S NAME____DATE OF LAST PHYSICAL EXAM_______________________

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING—INDICATE WITH A ☑

- ☐ **Allergies to drugs__________________________**
- ☐ **Allergies to anesthetics______________________**
- ☐ **Any heart ailments**
- ☐ **High blood pressure**
- ☐ **Neurological problems**
- ☐ **Radiation treatments________________________**
- ☐ **Excessive bleeding from cuts or extractions**
- ☐ **Anemia or blood problems**
- ☐ **Arthritis**
- ☐ **Artificial heart valve**
- ☐ **Asthma**
- ☐ **Hay fever or allergies in general**
- ☐ **Diabetes**
- ☐ **Kidney problems**
- ☐ **Liver problems or hepatitis**
- ☐ **Malignancies**
- ☐ **Psychiatric care**
- ☐ **Headaches**
- ☐ **Sinus problems**
- ☐ **Joint replacement,when_________________Doctor___________________________**
- ☐ **Stroke**
- ☐ **Thyroid**
- ☐ **Eye disorders**
- ☐ **Tonsillitis**
- ☐ **Tuberculosis**
- ☐ **Ulcer or colitis**
- ☐ **Pregnancy, what month?_____________**
- ☐ **Venereal diseases**
- ☐ **Aids/HIV**

DESCRIBE ANY CURRENT MEDICAL TREATMENT INCLUDING DRUGS TAKEN____

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SIGNATURE____DATE__________________________

PATIENT, PARENT OR GUARDIAN