CONFIDENTIAL DENTAL AND MEDICAL HISTORY

Gregory A. Archambault, D.M.D.

Patient's Name_____ Age_____ Birthdate_____ Today's Date_____

Address_____
Street *City* *State* *Zip*

Phone:
Home_____ Cell_____ Work_____ Email:_____

Place Employed_____ Occupation_____

SS#_____-_____-_____ Marital Status: S M D W Spouse_____

Person responsible for this account:_____ Whom may we thank for referring you?_____

HAVE YOU EVER HAD OR DO YOU NOW HAVE ANY OF THE FOLLOWING: (Please circle Yes or No)

Abnormal Blood Pressure	Yes No	Diabetes	Yes No	Pacemaker	Yes No
AIDS	Yes No	Drug Dependency	Yes No	Polio	Yes No
Allergies	Yes No	Epilepsy	Yes No	Prolonged Bleeding	Yes No
Anemia	Yes No	Fainting	Yes No	Prolonged Cough	Yes No
Angina	Yes No	Glaucoma	Yes No	Psychiatric Treatment	Yes No
Arthritis	Yes No	Heart Disease	Yes No	Radiation Therapy	Yes No
Artificial Heart Valves	Yes No	Heart Murmur	Yes No	Rheumatic Fever	Yes No
Artificial Joints	Yes No	Hepatitis	Yes No	Sickle Cell Anemia	Yes No
Asthma	Yes No	Herpes	Yes No	Stroke	Yes No
Cancer	Yes No	Jaundice	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Kidney Disease	Yes No	Tuberculosis	Yes No
Congenital Heart Lesions	Yes No	Organ Transplant	Yes No	Venereal Disease	Yes No

ARE YOU *ALLERGIC* TO OR HAVE A *REACTION* TO:

Local Anesthetics	Yes No
Penicillin	Yes No
Other Antibiotic(s):_____	Yes No
Aspirin	Yes No
Codeine or other narcotics	Yes No
Metals or Jewelry	Yes No
Other:_____	

Comments:

_____

_____

_____

Are you taking medication now? If yes, please list_____	Yes No
_____	
Name of Physician_____	
Are you in good health?	Yes No
Have you been under a physician's care during the last 2 years? For?_____	Yes No
Have you ever had major surgery?_____	Yes No
Have you ever tested positive for Hepatitis?	Yes No
Have you ever required pre-medication with antibiotics before dental work?_____	Yes No
Do you have any disease, condition, or problem not listed?_____	Yes No
Women: Are you pregnant now?	Yes No
Are you using birth control pills	Yes No
Do you anticipate becoming pregnant?	Yes No

PLEASE READ CAREFULLY:
To the best of my knowledge all of the preceding answers are true and correct. If I ever have a change in my health, I will inform the office at the next appointment. I do hereby authorize and request for me or the above named patient, dental services and/or whatever procedures the doctor may deem necessary. I also authorize the administration of those local anesthetics or premedications, which may be deemed advisable. I will be responsible for any financial obligation for treatment on me or the above named dependent.

_____ _____ _____
Date Signature of Patient, Parent, or Guardian Doctor's Signature

PLEASE COMPLETE REVERSE SIDE

Dental History

Do your gums bleed while brushing or flossing? ..... Yes No
Do your gums feel tender or swollen? ..... Yes No
Do you ever have a bad taste or smell in your mouth? ..... Yes No
Are you aware of any teeth being loose, drifting or moving? ..... Yes No
Do you feel pain to any teeth when brushing or flossing? ..... Yes No
Do you clench or grind your jaws while sleeping or during the day? ..... Yes No
Do your jaws feel tired? ..... Yes No
Does your mouth feel dry? ..... Yes No
Do you wear partial(s) or full denture(s)? ..... Yes No
Do you gag easily? ..... Yes No
Do you smoke? ..... Yes No
Do you drink soft drinks? How many per day?_____ ..... Yes No
Do you eat hard candy? ..... Yes No
Do you chew ice? ..... Yes No
Do you bite your fingernails? ..... Yes No
Have you every had Nitrous Oxide (laughing gas)? ..... Yes No
Do you use an appliance or CPAP for sleep apnea? ..... Yes No
Have you had any of the following treatments? ..... Yes No
a) Orthodontics (braces) Dr. _____When?_____ ..... Yes No
b) Endodontics (root canal) Dr._____ ..... Yes No
c) Periodontics (gum surgery or deep cleaning) Dr._____ When?_____ ..... Yes No
Have you ever had your teeth whitened? ..... Yes No
Strips____ Trays_____In Office_____ Other_____
How often do you brush your teeth?_____
What texture brush do you use? Soft Medium Hard Electric_____
How often do you floss? _____ Do you use a Waterpik or AirFlosser? Y/N
Do you wear a bite guard for clenching and grinding? ..... Yes No
If so, which material: Hard Soft

Reason for today's visit:_____
Are you having pain or discomfort at this time? ..... Yes No
If yes, circle area of discomfort: Upper: Right Left Front
Lower: Right Left Front
Do you feel discomfort when your teeth come in contact with:
a) hot foods or liquids (soup, coffee, etc.)? ..... Yes No
b) cold foods or liquids (ice cream, fruit, etc.)? ..... Yes No
c) sweets (candy, chocolate, etc.)? ..... Yes No
d) sours (lemons, grapefruit, etc.)? ..... Yes No

When was your last dental visit?_____What was performed?_____
Date (if known) of the last x-rays: Panoramic/Full Set_____ Bitewings_____ Other_____
Do you feel nervous or anxious about having dental treatment? ..... Yes No
Have you ever had a bad experience in the dental office? If so, please describe: ..... Yes No
_____
_____

Please add anything you feel is important: _____
_____

_____
Patient Signature (Parent if under 18)