Patient Name: _____ Osprey Dental, LLC

DENTAL HISTORY

Please check any of the following problems that apply to you:

- ❑ Sensitivity (Hot; Cold, Sweet, Pressure)
  Where? UR LR UL LL
- ❑ Headaches, earaches, neck pain
- ❑ Jaw joint pain
- ❑ Teeth or fillings breaking
- ❑ Grinding or clenching teeth
- ❑ Bleeding, swollen or irritated gums
- ❑ Loose, tipped or shifting teeth
- ❑ Bad breath

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

- ❑ Dentures/Partial Dentures
- ❑ Dental Implants
- ❑ Braces
- ❑ Periodontal (gum) treatments

When was your last cleaning?_____

When were your last complete x-rays? _____

Name of Previous Dentist: _____

Why did you leave your previous dentist? _____

If you could whiten your teeth for a cost anyone could afford, would you do it? ❑ Yes ❑ No

Do you smoke or use chewing tobacco? ❑ Yes ❑ No

How much? _____ For how long?_____

If you could change your smile, you would:

- ❑ Make them whiter
- ❑ Make them straighter
- ❑ Close spaces
- ❑ Replace black metal fillings w/tooth colored restorations
- ❑ Repair chipped teeth
- ❑ Repair missing teeth
- ❑ Replace old crowns that don't match
- ❑ Have a smile makeover

ON A SCALE OF 1-10, WITH 10 BEING THE HIGHEST RATING:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Where do you want your dental health to be?

1 2 3 4 5 6 7 8 9 10

What is the most important thing to you about your future smile and dental health?_____

What is the most important thing to you about your dental visit today?_____

MEDICAL HISTORY

Are you under a physician's care now? ❑ Yes ❑ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ❑ Yes ❑ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ❑ Yes ❑ No If yes, please explain: _____

Are you taking any medications, pills or drugs? ❑ Yes ❑ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ❑ Yes ❑ No _____

Do you take, or have you taken, Bisphosphonates such as Fosamax, Boniva, Actonel, or Reclast? ❑ Yes ❑ No _____

Are you on a special diet? ❑ Yes ❑ No

WOMEN: Are you pregnant/trying to get pregnant? ❑ Yes ❑ No Taking oral contraceptives? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No

Are you allergic to any of the following? ❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Metal ❑ Latex ❑ Local Anesthetics ❑ Sulfa ❑ Other If yes, please explain: _____

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

AIDS/HIV Positive	❑ Yes	❑ No	Cortisone Medicine	❑ Yes	❑ No	Hemophilia	❑ Yes	❑ No	Renal Dialysis	❑ Yes	❑ No
Alzheimer's Disease	❑ Yes	❑ No	Diabetes	❑ Yes	❑ No	Hepatitis A	❑ Yes	❑ No	Rheumatic Fever	❑ Yes	❑ No
Anaphylaxis	❑ Yes	❑ No	Drug Addiction	❑ Yes	❑ No	Hepatitis B or C	❑ Yes	❑ No	Rheumatism	❑ Yes	❑ No
Anemia	❑ Yes	❑ No	Easily Winded	❑ Yes	❑ No	Herpes	❑ Yes	❑ No	Scarlet Fever	❑ Yes	❑ No
Angina	❑ Yes	❑ No	Emphysema	❑ Yes	❑ No	High Blood Pressure	❑ Yes	❑ No	Shingles	❑ Yes	❑ No
Arthritis/Gout	❑ Yes	❑ No	Epilepsy or Seizures	❑ Yes	❑ No	Hives or Rash	❑ Yes	❑ No	Sickle Cell Disease	❑ Yes	❑ No
Artificial Heart Valve	❑ Yes	❑ No	Excessive Bleeding	❑ Yes	❑ No	Hypoglycemia	❑ Yes	❑ No	Sinus Trouble	❑ Yes	❑ No
Artificial Joint	❑ Yes	❑ No	Excessive Thirst	❑ Yes	❑ No	Irregular Heartbeat	❑ Yes	❑ No	Spina Bifida	❑ Yes	❑ No
Asthma	❑ Yes	❑ No	Fainting Spells/Dizziness	❑ Yes	❑ No	Kidney Problems	❑ Yes	❑ No	Stomach/ Intestinal Disease	❑ Yes	❑ No
Blood Disease	❑ Yes	❑ No	Frequent Cough	❑ Yes	❑ No	Leukemia	❑ Yes	❑ No	Stroke	❑ Yes	❑ No
Blood Transfusion	❑ Yes	❑ No	Frequent Diarrhea	❑ Yes	❑ No	Liver Disease	❑ Yes	❑ No	Swelling of Limbs	❑ Yes	❑ No
Breathing Problem	❑ Yes	❑ No	Frequent Headaches	❑ Yes	❑ No	Low Blood Pressure	❑ Yes	❑ No	Thyroid Disease	❑ Yes	❑ No
Bruise Easily	❑ Yes	❑ No	Genital Herpes	❑ Yes	❑ No	Lung Disease	❑ Yes	❑ No	Tonsillitis	❑ Yes	❑ No
Cancer	❑ Yes	❑ No	Glaucoma	❑ Yes	❑ No	Mitral Valve Prolapse	❑ Yes	❑ No	Tuberculosis	❑ Yes	❑ No
Chemotherapy	❑ Yes	❑ No	Hay Fever	❑ Yes	❑ No	Pain in Jaw Joints	❑ Yes	❑ No	Tumors or Growths	❑ Yes	❑ No
Chest Pains	❑ Yes	❑ No	Heart Attack/Failure	❑ Yes	❑ No	Parathyroid Disease	❑ Yes	❑ No	Ulcers	❑ Yes	❑ No
Cold Sores/Fever Blisters	❑ Yes	❑ No	Heart Murmur	❑ Yes	❑ No	Psychiatric Care	❑ Yes	❑ No	Venereal Disease	❑ Yes	❑ No
Congenital Heart Disorder	❑ Yes	❑ No	Heart Pace Maker	❑ Yes	❑ No	Radiation Treatments	❑ Yes	❑ No	Yellow Jaundice	❑ Yes	❑ No
Convulsions	❑ Yes	❑ No	Heart Trouble/Disease	❑ Yes	❑ No	Recent Weight Loss	❑ Yes	❑ No			

Have you ever had any serious illness not listed above? ❑ Yes ❑ No If yes, please explain: _____

Family Physician:_____ Phone Number: _____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN: _____ **DATE:** _____