# Clean Smiles Pediatric Dentistry

## Health and Dental History

Today's Date: _____ Appointment Date: _____ Time: _____

Patient Name:_____ Nickname:_____ Birth Date:_____
Last First MI

Parent/Guardian (if applicable):_____ Patient Age:_____

___Male ___Female ___ Married ___Single ___Child ___Other

## Phone Numbers:

*Home:*_____ *Work:*_____ *Cell:*_____

Email Address: _____

Address:_____
Street Apartment #

City: _____ State: _____ Zip: _____ SSN#_____

## Health Information

Date of Last Dental Visit: _____ Reason for Visit:_____

Are You Currently in Any Dental Pain Right Now? Yes No
If yes, Please explain_____

Have You Ever Had Any Complications During or Following Dental Treatment? Yes No
If Yes, Please Explain:_____

Are You Unhappy About Your Smile? Yes No
If Yes, Please Explain:_____

Have You Had Braces? Yes No
If Yes, Please List Orthodontist's Name and Number:_____

Are You Aware of Having an Allergic Reaction to Any Medication or Substance? Yes No
If Yes, Please Explain:_____

Do You Smoke or Drink? Yes No
If Yes, Please Explain:_____

Are You Taking/Using any Recreational Drugs? Yes No
If Yes, Please Explain:_____

Are you Pregnant, Nursing, or Trying to Become Pregnant? Yes No
If Yes, When is Your Due Date:_____

Are You Taking Birth Control Pills? Yes No
If Yes, Please Provide Name:_____

Have You Been Admitted to the Hospital or Needed Emergency Care During The Past Two Years? Yes No
If Yes, Please Explain:_____

Are You now Under The Care of a Physician? Yes No
If Yes, Please Explain:_____

Are You Taking Any Medications? Yes No
If Yes, Please List Name And Dose:_____

**HAVE YOU EVER EXPERIENCED OR HAD ANY OF THE FOLLOWING? PLEASE CIRCLE YES OR NO TO EACH ITEM.**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| AIDS/HIV | Yes | No | Grinding of Teeth | Yes | No | Prosthetic Heart Valve | Yes | No |
| Allergies | Yes | No | Growths | Yes | No | Radiation Treatment | Yes | No |
| Anemia | Yes | No | Hay Fever | Yes | No | Respiratory Problems | Yes | No |
| Arthritis/Rheumatism | Yes | No | Hardening of the Arteries | Yes | No | Rheumatic Fever | Yes | No |
| Artificial Joints | Yes | No | Headaches | Yes | No | Ringing of Ears | Yes | No |
| Artificial Heart Valve | Yes | No | Head Injuries | Yes | No | Sensitive Teeth | Yes | No |
| Asthma | Yes | No | Heart Attack | Yes | No | Sexually Transmitted Disease | Yes | No |
| Bell's Palsy | Yes | No | Heart Disease | Yes | No | Shortness of Breath | Yes | No |
| Bladder Disease/Problems | Yes | No | Heart Murmur | Yes | No | Sickle Cell Disease | Yes | No |
| Bleeding Problems | Yes | No | Heart Defects | Yes | No | Sinus Problems | Yes | No |
| Blood Disease | Yes | No | Heart Problems | Yes | No | Skin Disease | Yes | No |
| Blood Transfusions | Yes | No | Hepatitis A B C or D | Yes | No | Stomach Problems | Yes | No |
| Bruise Easily | Yes | No | Herpes | Yes | No | Stroke | Yes | No |
| Cancer | Yes | No | High Blood Pressure | Yes | No | Surgeries | Yes | No |
| Chemotherapy | Yes | No | Insomnia/Frequent Waking | Yes | No | Swollen Ankles | Yes | No |
| Chest Pain | Yes | No | Jaundice | Yes | No | Thyroid Problems | Yes | No |
| Clenching of Teeth | Yes | No | Jaw Pain | Yes | No | Tingling in Arms/Fingers | Yes | No |
| Congested Ears | Yes | No | Jaw Popping | Yes | No | Trigeminal Neuralgia | Yes | No |
| COPD | Yes | No | Kidney Disease | Yes | No | Tuberculosis | Yes | No |
| Diabetes | Yes | No | Latex Allergy/Sensitivity | Yes | No | Tumors | Yes | No |
| Difficulty Chewing | Yes | No | Limited Opening | Yes | No | Ulcers | Yes | No |
| Difficulty Swallowing | Yes | No | Liver Disease | Yes | No | Weight Loss/Gain | Yes | No |
| Dizziness | Yes | No | Loose Teeth | Yes | No | | | |

Do you have or have you had any disease, condition or problem not listed? Yes No

If Yes, Please
Explain:_____

Does Food Pack or Catch Between Your Teeth? Yes No

Do Your Gums Bleed? Yes No

Does Your Breath Concern You? Yes No

## Dental Insurance Information

Insured's Name_____ Insured's Social Security # _____

Insurance Company_____ Group No._____ Local No. _____

Insurance Co. Address_____ Phone No. _____

Do you have dual coverage? Yes_____ No_____ If yes:

Insured's Name_____ Insured's Social Security # _____

Insurance Company_____ Group No._____ Local No. _____

Insurance Co. Address_____ Phone No. _____