Kyle A. Smits D.D.S., PLLC

Dental History

Patient's Name:_____Age:_____Date:_____
If completing for someone other than yourself, please print your name and relationship to the patient:

_____

Former Dentist:_____

Reason for today's visit:_____

Date of last exam:_____ Date of last dental X-rays:_____

How often do you brush?_____ How often do you floss?_____

Please check any of the following that apply to you at this time:

____Bad breath	____Bleeding gums	____Broken teeth or fillings
____Loose teeth	____Periodontal treatment	____Dental fear
____Grinding teeth	____Sore jaw muscles	____Clicking or popping jaw
____Sores or growths in your mouth	____Cold or heat sensitivity	____Take fluoride supplements
____Sweet sensitivity	____Pressure sensitivity	_____

____Have you experienced breathing laughing gas (nitrous oxide) with your dental treatment?
____*Would you prefer* using laughing gas (nitrous oxide) with your dental treatment?
____Need to take antibiotics before dental treatment. Why?_____
____Are you taking or have you taken Fosamax, Boniva, Actonel or other forms of bisphosphonate therapy?
____Have experienced a reaction to penicillin, dental anesthetic or other.
Please specify and describe:_____

Emergency contact:_____ **Phone**_____**Relationship**_____
Physician_____**Phone**_____

MEDICAL HISTORY (Please circle if have or have had.)

Hives, skin rash, Hay Fever
Any reaction to:
Jewelry or metal
Aspirin
Penicillin, antibiotics, Sulfa
Codeine or other narcotics
Dental anesthetic
Other medications
Allergy to Latex
Arthritis
Asthma, Sinus trouble
Tumor or abnormal growth
Radiation treatment, chemotherapy
Any form of cancer_____
Taking any medications regularly now or in the past year (list below or on back)_____
_____
_____
Emphysema

Stroke
Joint replacements
Type_____Date____
Prolonged bleeding
Thyroid/Parathyroid disorder
Herpes, Venereal Disease, HPV
Kidney disease
Hepatitis, A B or C (Circle which)
Liver disease
Diabetes
Alcoholism
Epilepsy or seizures
Tuberculosis
Heart trouble
If female are you now:
Pregnant
Taking oral contraceptives
_____
• Rheumatic fever

Heart murmur
Arteriosclerosis
High blood pressure
Excessive swollen ankles
Chest pain
HIV positive
Pace maker, Artificial heart valve
Are you presently being treated for any illness?
Do you smoke?
Have you smoked in the past?
Do you use smokeless tobacco?
Are you taking or have taken Fosamax,Boniva, Actonel or other forms of bisphosphonate therapy?
Other...._____
_____
_____

SIGNATURE_____ DATE _____