EVANSTONDENTALASSOCIATES, LTD
Joseph B. Silberman, DMD, FAGD

Welcome! So that we may provide you with the best possible care, please complete the entire dental history form. All information will be kept completely confidential.

Today's Date_____

Purpose of your visit today _____

_____

Previous Dentist's Name_____

Address _____ City _____ State _____ Zip _____

Phone_____

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

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

Are any of your teeth sensitive to: (check all that apply) ❑ Hot ❑ Cold ❑ Sweets ❑ Biting ❑ Chewing

If yes, where? _____

Have you noticed any mouth odors or bad tastes? ❑ Yes ❑ No

Do you ever get cold sores, blisters or any other mouth/lip lesions? ❑ Yes ❑ No

Have you noticed any loose teeth or a change in your bite? ❑ Yes ❑ No

Does food tend to get caught in between your teeth? ❑ Yes ❑ No

Do you:

Clench or grind your teeth?	❑ Yes ❑ No	Smoke/chew tobacco?	❑ Yes ❑ No
Have tired jaws (esp. in the morning)?	❑ Yes ❑ No	Breathe through your mouth?	❑ Yes ❑ No
Frequently bite your lips or cheeks?	❑ Yes ❑ No	Hold foreign objects in your teeth?	❑ Yes ❑ No

Have you experienced:

Clicking/popping of the jaw?	❑ Yes ❑ No	Difficulty opening/closing your mouth?	❑ Yes ❑ No
Difficulty chewing?	❑ Yes ❑ No	Headaches, neck pain or shoulder pain?	❑ Yes ❑ No

Have you ever had:

Orthodontic treatment?	❑ Yes ❑ No	Oral Surgery?	❑ Yes ❑ No
Periodontal (Gum) treatment?	❑ Yes ❑ No	Your teeth ground or your bite adjusted?	❑ Yes ❑ No
A bite plate or mouth guard?	❑ Yes ❑ No	A serious injury to your mouth or head?	❑ Yes ❑ No

If yes, please describe _____

Are you satisfied with the appearance of your teeth? ❑ Yes ❑ No If no, please describe _____

_____

Do you feel nervous about having dental treatment? ❑ Yes ❑ No If yes, what is your biggest concern?

_____

Is there anything else about having dental treatment that you would like us to know? _____

_____

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Medical History Form

Patient Name

Have you been under the care of a medical doctor during the past two years? ❑ Yes ❑ No

If yes, for what? _____

Physician's Name _____

Are you taking any medications now? ❑ Yes ❑ No If yes, please list name and dosage:

_____

Are you allergic or have adverse reaction to any medications? ❑ Yes ❑ No If yes, please list them:

_____

Do you have a latex allergy? ❑ Yes ❑ No

Have you been hospitalized during the past five years? ❑ Yes ❑ No If yes, please describe:

_____

Indicate which of the following you have had, or have at present:

Heart (Surgery, Disease, Attack)	❑ Yes ❑ No	Ulcers	❑ Yes ❑ No
Chest Pain	❑ Yes ❑ No	Diabetes	❑ Yes ❑ No
Heart Murmur	❑ Yes ❑ No	Thyroid Problems	❑ Yes ❑ No
High Blood Pressure	❑ Yes ❑ No	Glaucoma	❑ Yes ❑ No
Mitral Valve Prolapse	❑ Yes ❑ No	Emphysema	❑ Yes ❑ No
Artificial Heart Valve	❑ Yes ❑ No	Chronic Cough	❑ Yes ❑ No
Heart Pacemaker	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No
Rheumatic Fever	❑ Yes ❑ No	Asthma	❑ Yes ❑ No
Arthritis/Rheumatism	❑ Yes ❑ No	Hay Fever	❑ Yes ❑ No
Swollen ankles	❑ Yes ❑ No	Sinus trouble	❑ Yes ❑ No
Stroke	❑ Yes ❑ No	Radiation Therapy	❑ Yes ❑ No
Artificial joints	❑ Yes ❑ No	Chemotherapy	❑ Yes ❑ No
Kidney trouble	❑ Yes ❑ No	Tumors	❑ Yes ❑ No
Hepatitis A,B,or C	❑ Yes ❑ No	Venereal disease	❑ Yes ❑ No
AIDS	❑ Yes ❑ No	HIV positive	❑ Yes ❑ No
Blood transfusion	❑ Yes ❑ No	Hemophilia	❑ Yes ❑ No
Sickle Cell disease	❑ Yes ❑ No	Bruise easily	❑ Yes ❑ No
Liver disease	❑ Yes ❑ No	Jaundice	❑ Yes ❑ No
Neurological disorders	❑ Yes ❑ No	Epilepsy or Seizures	❑ Yes ❑ No
Fainting or dizzy spells	❑ Yes ❑ No	Psychological Care	❑ Yes ❑ No

Have you ever been treated with Botox or Dermal Fillers (Restylane, Juvaderm)? ❑ Yes ❑ No

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

If yes, please list: _____

Women: Are you pregnant? ❑ Yes, ____ months ❑ No Are you nursing? ❑ Yes ❑ No

Taking birth control pills? ❑ Yes ❑ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date _____