

Joseph B. Silberman, DMD, MAGD

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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Smoke/chew tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have tired jaws (esp. in the morning)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Breathe through your mouth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Frequently bite your lips or cheeks?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hold foreign objects in your teeth?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Have you experienced:**

Clicking/popping of the jaw?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty opening/closing your mouth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Difficulty chewing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches, neck pain or shoulder pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Have you ever had:**

Orthodontic treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Oral Surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Periodontal (Gum) treatment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Your teeth ground or your bite adjusted?	<input type="checkbox"/> Yes <input type="checkbox"/> No
A bite plate or mouth guard?	<input type="checkbox"/> Yes <input type="checkbox"/> No	A serious injury to your mouth or head?	<input type="checkbox"/> Yes <input type="checkbox"/> 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? \_\_\_\_\_  
 \_\_\_\_\_

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