PIPPIN DENTAL CARE

MEDICAL HISTORY

PLEASE COMPLETE ALL INFORMATION - THANK YOU

Patient Last Name: _____ **Patient First Name:** _____

Are you under a physician's care? Yes❑ No❑ Physician's name_____ Date of last visit_____

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

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

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

Do you use controlled substances? Yes❑ No❑ If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? Yes❑ No❑ If yes, please explain:_____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphophonates? Yes❑ No❑ If yes, please describe: _____

_____

Are you on a special diet? Yes❑ No❑ Do you use tobacco? Yes❑ No❑ Do you use recreational drugs? Yes❑ No❑

(Women) Are you pregnant/trying to become pregnant? Yes❑ No❑ Due date_____ Nursing? Yes❑ No❑ Taking oral contraceptives? Yes❑ No❑

Are you allergic to any of the following?

❑ Aspirin ❑ Penicilin ❑ Codeine ❑ Acrylic

❑ Metal ❑ Latex ❑ Suifa Drugs ❑ Local Anesthetic

❑ Other _____

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

Please check if you have/had:	Yes	No	Please check if you have/had:	Yes	No	Please check if you have/had:	Yes	No
Acid Reflux			Allergies or hay fever			Anemia		
Angina or chest pain			Anxiety or panic attack			Arthritis, Rheumatism		
Artificial heart valve			Artificial joint			Asthma		
Autoimmune disease			Bleeding abnormally with surgery			Blood disease, clotting disorder		
Blood thinner			Cancer			Chemical dependency		
Chemotherapy			Cough, persistent or bloody			Depression		
Diabetes			Emphysema			Epilepsy or seizures		
Fainting			Glaucoma			Headaches		
Heart murmur			Heart problems			Hepatitis Type B or C		
HIV or AIDS			High blood pressure			Jaundice		
Kidney disease			Low blood pressure			Osteopenia		
Pacemaker			Psychiatric treatment			Radiation treatments		
Respiratory disease			Rheumatic fever			Scarlet fever		
Shortness of breath			Sinus problems			Sickle cell anemia		
Skin rash or hives			Snoring or sleep apnea			Stroke		
Swelling of feet or ankles			Substance abuse			Thyroid problems		
Tonsilitis			Tuberculosis			Tumor or growth on head/neck		
Ulcers of stomach			Weight loss, unexplained			Alzheimers or dementia		
Bruise easily			Osteoporosis			Mitral Valve Prolapse		
Circulatory problems			Cortisone/Steroid treatment			COPD		

AUTHORIZATION AND RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient/Guardian Signature: _____ Date:_____

Over...

1106 Glennhill Lane, Sevierville, TN 37862 • 865-453-6789 • wecare@pippindentalcare.com

PIPPIN DENTAL CARE

DENTAL HISTORY

Patient Last Name: _____ **Patient First Name:** _____

Please state the purpose of your visit: _____

_____

_____

_____

Please check if you have/had:	Yes	No	Please check if you have/had:	Yes	No	Please check if you have/had:	Yes	No
Sensitivity to chewing pressure			Sensitivity to sweets			Sensitivity to cold		
Sensetivity to heat			Chewing on one side only			Food collection between teeth		
Cigar,cigarette, or pipe smoking			Smokeless tobacco use			Vaping		
Frequent dry mouth			Jaw joint or TMJ pain			Jaw joint popping		
Jaw locked open or closed			Clenching or grinding of teeth			Bite appliance or night guard		
Lip, cheek, or nail biting			Braces or orthodontics			CPAP		
Snoring or sleep apnea			Bad breath			Bleeding gums		
Periodonntal or gum surgery			Receeding gums			Frequent mouth sores or ulcers		
Tumor or growth on face, mouth, neck			Difficulty getting numb			Reaction to local anesthetic (Novacaine)		
Nitrous oxide gas			Tinnitus or ringing in ears			Bleaching or whitening of teeth		
Gag easily								

Are you uncomfortable or self-concious about the appearance of your teeth? Yes❑ No❑ If yes, please describe:_____

Have you been disappointed with the appearance of previous dental work? Yes❑ No❑ If yes, please describe _____

Are your teeth becoming more crooked or overlapping? Yes❑ No❑ If yes, please describe: _____

Are your teeth becoming worn, shorter, or thinner? Yes❑ No❑ If yes, please describe: _____

Are you interested in whiter teeth? Yes❑ No❑ If yes, please describe: _____

Are you interested in straighter teeth or having spaces closed? Yes❑ No❑ If yes, please describe: _____

Are you interested in replacement of missing teeth? Yes❑ No❑ If yes, please describe: _____

Have you had complications with previous dental treatment? Yes❑ No❑ If yes, please describe: _____

Are you interested in facial wrinkle reduction? Yes❑ No❑

Are you interested in lip enhancement? Yes❑ No❑

On a scale of 0-5 how high would you score your level of anxiety regarding dental treatment? _____

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

_____

Patient/Guardian Signature

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