Simply Dental
011-52 (658) 517-7634

Date _____
mm / dd / yyyy

Name _____ Age _____
Last First

Address _____City _____ State _____

Zip Code_____ Telephone _____ Cell Phone _____

Email _____ Occupation _____ Referred by _____

MEDICAL HISTORY

	YES	NO
1.- Are you in good health?	☐	☐
2.- Have you been treated by your medical doctor in the last 5 years?	☐	☐
3.- Are you taking any medication? If yes give name please _____	☐	☐
4.- Are you allergic to anesthesia, penicillin, antibiotics or other medication? 5.- Have you ever had any bad experience with other dentist in the past ? 6.- Do you have any excessive bleeding ?	☐	☐
7.- Circle any of the following health problems you have or had had before? Aids, Diabetes, Epilepsy, Heart Trouble, Heart Attack, Hypertension, Hypotension, Hepatitis, Cancer, Other _____	☐	☐
8.- Are you pregnant? Specified in what week _____	☐	☐

DENTAL HISTORY

1.- Do you have a specific dental problem? Describe _____	☐	☐
2.- Do you have dental examinations on a routine basis? Last visit _____	☐	☐
3.- Do you think you have active decay or gum disease? _____	☐	☐
4.- Do you brush and floss on a routine basis? Discuss _____	☐	☐
5.- Do your gums ever bleed? Discuss _____	☐	☐
6.- Does food catch between your teeth? Any loose teeth? _____	☐	☐
7.- Do you want to keep your remaining teeth? _____	☐	☐
8.- Do you ever have clicking, poping or discomfort in the jaw joint? Do you brux or grind?	☐	☐
9.- Do you smoke or chew tobacco? _____	☐	☐
10.- Any sores or growths in your mouth? Discuss _____	☐	☐
11.- Date of last full mouth x-rays (16 small films or panoramic) _____	☐	☐