

# LEVY DENTAL GROUP

PATIENT NAME \_\_\_\_\_ DATE \_\_\_\_\_

Primary Reason for this dental appointment:  Examination  Emergency  Consultation

## DENTAL HISTORY

Do you have a specific dental problem. Describe \_\_\_\_\_ Yes No

Do you have dental examinations on a routine basis? Last visit \_\_\_\_\_ Yes No

Do you think you have active decay or gum disease? \_\_\_\_\_ Yes No

Do you brush and floss on a routine basis? Discuss. \_\_\_\_\_ Yes No

Do your gums ever bleed? Discuss. \_\_\_\_\_ Yes No

Do you like your smile? Why? \_\_\_\_\_ Yes No

Does food catch between your teeth? Any loose teeth? \_\_\_\_\_ Yes No

Do you want to keep your remaining teeth? \_\_\_\_\_ Yes No

Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? \_\_\_\_\_ Yes No

Have your past experiences in a dental office always been positive? \_\_\_\_\_ Yes No

Do you smoke or chew? Any sores or growths in your mouth? Discuss. \_\_\_\_\_ Yes No

Name of previous dentist (optional) \_\_\_\_\_

Date of last full mouth x-ray (16 small films or panoramic) \_\_\_\_\_

## MEDICAL HISTORY

Are you under a physician's care now? Why? \_\_\_\_\_ Yes No

Who? \_\_\_\_\_ Phone \_\_\_\_\_

Have you ever been hospitalized or had a major operation? Discuss. \_\_\_\_\_ Yes No

Have you ever had a serious injury to your head or neck? Discuss. \_\_\_\_\_ Yes No

Are you taking any medications, pills or drug? What? \_\_\_\_\_ Yes No

Ever taken fen-phen? \_\_\_\_\_ Yes No

Are you on a special diet? Discuss. \_\_\_\_\_ Yes No

Are you allergic to any medications or substances. \_\_\_\_\_ Yes No

Aspirin  Penicillin  Codeine  Acrylic  Latex Rubber  Other

Women (please check):  Pregnant/trying to get pregnant  Nursing  Taking oral contraceptives Discuss. \_\_\_\_\_