NORTH STAR DENTISTRY

History, continued

Patient Name:_____

Other family members seen by us? _____**Current/Previous Dentist**_____

Would you like us to request your records from your previous dentist? YES / NO

What qualities do you look for in choosing a dentist? _____

Why did you leave your last dentist? _____

If you could change anything about your smile, what would it be?_____

Describe your current health _____

Are you currently in pain? YES / NO if yes, Describe _____

How often do you floss? _____ **Do your gums ever bleed?** _____ **Do you ever have jaw joint pain YES / NO**

Are you under a physician's care? **YES / NO** _____

Physician's Name _____

Have you ever been hospitalized/major surgery? **YES / NO** _____

Are you in pain? **YES / NO** _____

Do you have problems laying back? **YES / NO** _____

Have you ever had a bad experience in a dental office? **YES / NO** _____

Are you nervous about dental treatment? **YES / NO** _____

Do you use, or have your used, Phen-Fen or Redux? **YES / NO** _____

Are you on a special diet? **YES / NO** _____

Do you use/have used tobacco? **YES / NO** _____

Do You use/have used controlled substance? **YES / NO** _____

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.

_____

Signature of Patient, Parent, Guardian **Date**

Office use only

Date _____**, Initals** _____**, BP**_____/_____**, Pulse**_____

Dr. _____**Date**_____