Encinitas Dental Art

1445 Encinitas Blvd • Encinitas, CA 92024 (760)942-7272

Medical History

Patient Name: _____ * _____ * ____ _____
Last First MI Preferred Name

Name and phone number of Primary Care Physician: *

_____

_____

Have you ever had surgery or been hospitalized? * ◯ Yes ◯ No

If yes, please explain:

_____

_____

List any medication you are currently taking:

_____

_____

Are you allergic to any medication? * ◯ Yes ◯ No

Do you smoke or use tobacco? * ◯ Yes ◯ No

Do experience shortness of breath? * ◯ Yes ◯ No

Do you use alcohol? * ◯ Yes ◯ No

If yes, how many drinks per week? _____

Have you lost or gained more than 10 lbs in the past year? * ◯ Yes ◯ No

Do you have an allergy to latex? * ◯ Yes ◯ No

Do you snore? * ◯ Yes ◯ No

FOR WOMEN ONLY

Are you currently taking any form of birth control? ◯ Yes ◯ No

Are you nursing? ◯ Yes ◯ No

Is there a chance you may be pregnant? ◯ Yes ◯ No

Have you ever had or do you currently have any of the following medical conditions?

- ☐ AIDS/HIV
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Eating Disorder
- ☐ Insomnia
- ☐ Osteoarthritis
- ☐ Cancer
- ☐ Artificial Joints
- ☐ Congestive Heart Failure
- ☐ Heart Murmur/Atrial Fibrilation
- ☐ Stroke
- ☐ Drug addition
- ☐ Mental Disorder
- ☐ Thyroid Disorder
- ☐ Hepatitis
- ☐ Blood Disease
- ☐ Chronic Fatigue
- ☐ General Allergies/Hay Fever
- ☐ Sleep Apnea
- ☐ Osteoporosis
- ☐ STDs
- ☐ Autoimmune Disorder
- ☐ Hypertension (high blood pressure)
- ☐ Pacemaker
- ☐ Artifical Joints
- ☐ Epilepsy/Seizures
- ☐ Nervous Disorder
- ☐ GERD (acid reflux)
- ☐ Arthiritis
- ☐ Anemia/Bleeding Disorder
- ☐ Difficulty Concentrating
- ☐ Head Injury
- ☐ Migraines
- ☐ Radition/Chemontherapy
- ☐ Tuberculosis
- ☐ Artificial Heart Valve/Replacement
- ☐ Heart Disease
- ☐ Mitral Valve Prolapse
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Sinus Problem
- ☐ Kidney Disease

Dental History

Please list the reason why you scheduled an appointment with our dental office? *

_____

_____

Approximate date of last dental visit * _____

Name of previous dentist * _____

Do you have any mouth pain at this time? * ◯ Yes ◯ No

Do you have any pain in your head or neck? * ◯ Yes ◯ No

Do you or have you been told that you clench or grind your teeth? * ◯ Yes ◯ No

Do you have any "clicks or pops" in your jaw upon opening or closing? * ◯ Yes ◯ No

Does your bite feel uneven? * ◯ Yes ◯ No

Do you experience frequent headaches? * ◯ Yes ◯ No

Have you ever worn braces or clear aligners? * ◯ Yes ◯ No

Do you currently wear any dental appliances? (partial dentures, retainers, nightguard, sleep apnea device) * ◯ Yes ◯ No

Have you ever had a crown done? * ◯ Yes ◯ No

If yes, please list the tooth number, month and year the crown(s) were done. _____

Are you fearful of the dentist? * ◯ Yes ◯ No

Do your gums ever bleed? * ◯ Yes ◯ No

How often do you brush your teeth?

◯ Daily ◯ 2-3 times per week ◯ Once per week ◯ Never

How often do you floss?

◯ Daily ◯ 2-3 times per week ◯ Once per week ◯ Never

Have you ever received periodontal treatment? Also known as deep cleanings * ◯ Yes ◯ No

If yes, please provide us with the date you had the deep cleanings done. _____

Have you ever had gum surgery or been under the care of a periodontist? * ◯ Yes ◯ No

Smile Evaluation

Are you happy with your smile? * ◯ Yes ◯ No

Do you have any spaces, overlaps, uneven edges or chips on your teeth? * ◯ Yes ◯ No

If you could change anything about your smile, what would it be? (check all that apply)

☐ Whiter teeth ☐ Shorter teeth ☐ Longer teeth ☐ Straighten teeth ☐ Eliminate silver fillings ☐ Fix chips or wear on

☐ * **I authorize the release of a full report of examination finding, diagnosis, treatment programs, etc. to any referring or treating dentist or physician. I additionally authorize the release of any medica information to insurance companies or for legal documentation to process claims. I understand that I am responsible for all fees for treatment regardless of insurance coverage.**

Response Date: _____