



David Schmidt D.D.S.

General & Cosmetic Dentistry

Name _____ Date of Birth _____ SS# _____

Email: _____ Phone _____

Address: _____

DENTAL HISTORY

Check if you have had problems with any of the following:

- | | | |
|-----------------|-------------------------------------|---------------------------|
| Bad Breath | Periodontal (gum) treatment | Sensitivity to hot |
| Loose teeth | Clicking or popping jaw | sensitivity to cold |
| Broken teeth | Clenching teeth, grinding, jaw pain | Sensitivity to sweets |
| Broken fillings | Use occlusal guard/bite guard | Sensitivity to chewing |
| Bleeding Gums | Food collection between teeth | Sores or growths in mouth |

Other information about your dental health or previous treatment _____

MEDICAL HISTORY

Physician's name _____ Phone _____

Have you had any serious illness or operations? Y N If yes, describe _____

Are you pregnant or trying to get pregnant? Y N Nursing? Y N Taking birth control pills? Y N

Please check the box if you have had any of the following:

- | | | |
|---------------------------------------|---------------------------------|--|
| AIDS/HIV positive | Chemotherapy | Dementia, Alzheimer's, Parkinson's |
| Tuberculosis | Asthma or COPD | Tobacco use or vape |
| Hepatitis | Diabetes | Recreational drugs |
| High blood pressure | Thyroid disease or malfunction | History of medication for osteoporosis (bisphosphonates) |
| Heart attack or heart defect | Hemophilia/abnormal bleeding | Latex allergy |
| Pacemaker and/or Defibrillator | Epilepsy, seizures, or fainting | Allergic to antibiotics |
| Artificial heart valves | Stroke | Anaphylactic allergic reaction |
| Artificial joints or surgical implant | Acid reflux | Antibiotic premedication needed |
| Cancer | Anxiety, depression | |

What medication, vitamins or herbal supplements are you taking? _____ Does patient have drug allergies? If yes, list all: _____

Emergency Contact _____ Relationship _____ Phone _____

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate treatment. If there is any change in my health or medication, I will inform the dentist.

Patient Signature _____ Date _____