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
- ☐ Loose teeth
- ☐ Broken teeth
- ☐ Broken fillings
- ☐ Bleeding Gums
- ☐ Periodontal (gum) treatment
- ☐ Clicking or popping jaw
- ☐ Clenching teeth, grinding, jaw pain
- ☐ Use occlusal guard/bite guard
- ☐ Food collection between teeth
- ☐ Sensitivity to hot
- ☐ sensitivity to cold
- ☐ Sensitivity to sweets
- ☐ Sensitivity to chewing
- ☐ 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
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Heart attack or heart defect
- ☐ Pacemaker and/or Defibrillator
- ☐ Artificial heart valves
- ☐ Artificial joints or surgical implant
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Asthma or COPD
- ☐ Diabetes
- ☐ Thyroid disease or malfunction
- ☐ Hemophilia/abnormal bleeding
- ☐ Epilepsy, seizures, or fainting
- ☐ Stroke
- ☐ Acid reflux
- ☐ Anxiety, depression
- ☐ Dementia, Alzheimer's, Parkinson's
- ☐ Tobacco use or vape
- ☐ Recreational drugs
- ☐ History of medication for osteoporosis (bisphosphonates)
- ☐ Latex allergy
- ☐ Allergic to antibiotics
- ☐ Anaphylactic allergic reaction
- ☐ Antibiotic premedication needed

What medication, vitamins or herbal supplements are you taking?

_____

_____

Does patient have drug allergies? If yes, list all:

_____

_____

Emergency Contact_____ **Relationship**_____ **Phone** _____

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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_____