Dr. Keith Jones, D.D.S.
Dr. Jeff Larkin, D.D.S.
Dr. Jeremy Robbins, D.D.S., P.A.

Patient Name:_____

Date:_____

- **This office does not discriminate on the basis of race, sex, sexual orientation, national origin, age, or disability.**
- **This office is in compliance with the latest state and federal infection control requirements**
- **This office protects the privacy of all patients.**

HEALTH HISTORY

Primary Physician's Name _____ **Phone #:** _____

	YES	NO
Are you under any medical treatment now?	☐	☐
If yes, please explain: _____		
Are you taking *any* daily medication?		
Vitamins, Minerals, Herbal Supplements, OTC	☐	☐
If yes, please list: _____		
Are you allergic to penicillin, amoxicillin, sulfa, local anesthetics, other medications, latex, vinyl, any metal or reaction to jewelry?	☐	☐
If yes, please list: _____		
Do you have a history of:		
Heart disease or stroke?	☐	☐
High or low blood pressure?	☐	☐
Circulatory problems?	☐	☐
Rheumatic fever, heart murmur, prolapsed valve?	☐	☐
Any prosthesis - hips, valves, shunts, pins, plates?	☐	☐
Diabetes, hypoglycemia, or kidney disease?	☐	☐
Anemia or bleeding problems?	☐	☐
Hepatitis, jaundice or liver disease?	☐	☐
AIDS or HIV infection?	☐	☐
Nervous problems?	☐	☐
Ulcers or herpetic lesions (fever blisters)?	☐	☐
Chemical dependency?	☐	☐
Tuberculosis or lung disease?	☐	☐

– OVER –

Arthritis or rheumatism?	☐	☐
Environmental allergies or sinus trouble?	☐	☐
Thyroid or endocrine disorder?	☐	☐
Cancer?	☐	☐

If yes, please explain: _____

Radiation or chemotherapy?	☐	☐
Fainting spells or seizures?	☐	☐
Breathing problems, asthma, or emphysema?	☐	☐
Do you smoke or chew tobacco?	☐	☐

Other? _____

DENTAL HISTORY

	YES	NO
Do you have a dental problem now?	☐	☐

If yes, please explain: _____

Do you have or have you been treated for TMJ problems?	☐	☐

If yes, please explain: _____

Do you clench or grind your teeth?	☐	☐
Do you wear a splint or mouthguard?	☐	☐
Are any of your teeth sensitive to hot, cold, or sweets?	☐	☐
Have you had gum treatment or surgery?	☐	☐
Have you ever had a root canal?	☐	☐
Have you ever had orthodontic treatment?	☐	☐
Do you frequently drink soda pop?	☐	☐
Do you regularly suck or chew on candies of any kind?	☐	☐
Are you happy with the appearance of your teeth?	☐	☐
Do you have any specific questions you would like to discuss?	☐	☐

_____

_____

When was your last dental visit and for what reason did you seek dental care? _____

_____

How often do you brush your teeth each day?

☐ 1-2 times ☐ 2-3 times ☐ 3 + times

How often do you floss? ☐ Daily ☐ Weekly ☐ Infrequently

How often and with what do you rinse? _____

_____ _____

Patient/Parent Signature Dentist's Signature

Date: _____ Date: _____