A M DeLoach DDS, LLC

Dental History

Current (or most recent) Physician:
Name_____Phone_____Location_____

Current (or most recent) Dentist:
Name_____Phone_____Location_____

Are you currently taking blood thinners such as:

- Coumadin
- Aspirin
- Other

Have you ever had a blood transfusion? ___Yes ___ No

Have you ever had a bad reaction to local anesthetic? ___Yes ___No

Have you ever had a bad reaction to nitrous oxide? ___Yes ___No

Do you have excessive bleeding? ___Yes ___No

Have you previously had difficult extractions? ___Yes ___No

Do you have a history of dry sockets? ___Yes ___No

Do you require antibiotic pre-medication prior to dental treatment? ___Yes ___No

Do you have allergies to any metals? ___Yes ___No

Do you have anxiety or sleep problems? ___Yes ___No

What was the date of your last dental cleaning?_____

Do you have any dental concerns? Including:

- Fear _____
- Time _____
- Money _____
- Tension _____
- Health _____

Are you happy with your smile? ___Yes ___No
If no, concerns:

_____

_____

Please select the conditions that previously or currently pertain to you?

- Smoke (#/day_____)
- Chew tobacco
- Abscess in mouth
- Food traps
- Bad breath
- Swelling
- Bad tastes
- Bleeding gums
- Bite nails/objects
- Staining
- Chew on one side
- Clench or grind teeth
- Cold sores
- Difficulty chewing
- Difficulty opening/closing
- Dry mouth
- Gag easily
- Headaches
- Loose teeth
- Missing teeth
- Pain by ears/jaw
- Sensitivity to Hot
- Sensitivity to Cold
- Sensitivity to Sweet
- Orthodontics
- Thumb/finger sucking
- Clicking/popping of jaw
- Partial/Full dentures

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 , or guardian _____ Date_____

Print Patient Name: _____