river's edge dental clinic
952.232.6454
16023 Elmhurst Lane, Suite 104
Lakeville, MN 55044
651.463.7777
Opening January 1st!
Farmington, MN 55024

Dental History

Name: _____
Last First Middle Initial Nickname

When did you last visit a dentist?_____ What was done then?_____
Former Dentist:_____ Phone: _____
Address: _____
Your current dental health is: Good_____ Fair_____ Poor_____ I don't know _____
How often do you: Brush_____ Floss_____ Other _____
Are you teeth sensitive to: Sweets_____ Cold_____ Hot_____ Pressure_____

_____ Yes _____ No Are you satisfied with your present smile? _____
_____ Yes _____ No Do you have concerns about dentistry now or in the past? _____
_____ Yes _____ No Are you aware of a dental problem? _____
_____ Yes _____ No Have you had a problem associated with previous dental treatment?_____
_____
_____ Yes _____ No Do you experience stress or anxiety when you visit a dental office?_____
_____ Yes _____ No Have you ever had or been evaluated for orthodontic treatment? _____
_____ Yes _____ No Is your water fluoridated?
_____ Yes _____ No Are you taking fluoride supplements?
_____ Yes _____ No Are you satisfied with your eating patterns? _____
_____ Yes _____ No Have you ever had any pain/tenderness/surgery in your jaw joints (TMJ)? _____
_____ Yes _____ No Are you under unusual stress at home or work? _____
_____ Yes _____ No Do you grind or clench your teeth? _____
_____ Yes _____ No Do you get frequent headaches? How often? _____
_____ Yes _____ No Do your gums ever bleed? When? Brushing / Floss / Dental Appointments / Spontaneously
_____ Yes _____ No Have you ever had gum treatment?_____
_____ Yes _____ No Do you know of any growths or sore spots in your mouth?_____
_____ Yes _____ No Do you have any speech problems? _____
_____ Yes _____ No Do you generally breathe through your mouth? When? Awake / Asleep
_____ Yes _____ No Have you ever had an injury to your: Mouth / Teeth / Head
Explain_____
_____

To be able to serve you more effectively, please complete the following:

How do you envision the health and appearance of your teeth 5 years from now?_____
How long do you plan to keep you own teeth? _____
In determining your dental treatment, what is the most important consideration to you:
(please rank from 1 to 5 1 = most important 5 = least important)

_____ The cost of treatment _____ How my teeth look _____ Avoid discomfort
_____ Eliminate future problems _____ How long it will take

River's Edge Dental Clinic is a preventive oriented comprehensive care dental clinic. Our goal is to maintain teeth for a life time. We believe that it is our professional duty to advise you of any condition we find that may affect your ability to keep your teeth now and in the future.

Medical History

Your Physician's Name: _____

Clinic: _____ Phone: _____

Address: _____

Are you currently under the care of a Physician? _____ No _____ Yes _____

Date of last physical examination: _____

List all over the counter drugs and prescriptions medications you are presently taking (including birth control pills):

_____

_____

Have you ever experienced any adverse effect from Dental Anesthetics, Penicillin, Erythromycin, Tetracycline, Codeine, Aspirin, other drugs, metal, plastic or latex? _____

Do you need to be premedicated before dental treatment for heart or other concerns? _____ Yes _____ No

Please check any health condition you have ever had or have now

	YES	NO		YES	NO		YES	NO
Rheumatic Fever	____	____	Hearing Impairment	____	____	Epilepsy/Seizures	____	____
Heart Murmur	____	____	Blindness	____	____	Fainting Spells	____	____
Implant	____	____	Frequent Mouth Sores	____	____	Sickle Cell Disease	____	____
Congenital Heart Defect	____	____	Hyperactivity	____	____	Tuberculosis (TB)	____	____
Mitral Valve Prolapse	____	____	Sinus Trouble	____	____	Arthritis or Rheumatism	____	____
Artificial Joints	____	____	Asthma	____	____	Alcohol Use	____	____
Artificial Heart Valve	____	____	Diabetes	____	____	How much per week?	____	
High/Low Blood Pressure	____	____	Immune System Disorders			Chemical Dependency	____	____
Heart Trouble	____	____	(HIV, ARC) other	____	____	Tobacco Use	____	____
Heart Surgery	____	____	Sexually Transmitted			What Type?	____	
Heart Pacemaker	____	____	Diseases	____	____	How much?	____	
Heart Attack/Stroke	____	____	Counseling	____	____	Caffeine Use	____	____
Hepatitis	____	____	Psychiatric Care	____	____	What Type?	____	
Kidney/Liver Problems	____	____	Cancer	____	____	How much?	____	
Anemia	____	____	Chemotherapy Treatment	____	____	Difficulty Breathing	____	____
Ulcer, Colitis or			Radiation Treatment	____	____	Dry Mouth/Xerostomia	____	____
Stomach Disorders	____	____	Tumors/Cysts/Growths	____	____	Attention Deficit Disorder	____	____
Emphysema	____	____	Hemophilia	____	____	Latex Allergy	____	____
Glaucoma	____	____	Abnormal Bleeding	____	____			
Contact Lenses	____	____	Metal Allergies	____	____			
Blood Transfusions	____	____	Handicaps/Disabilities	____	____			

Other condition, handicap or disease not listed above: _____

Major Surgery: _____

Women: Are you pregnant? (due date) _____ or you might be? _____ Are you nursing? (date) _____

History Updates

(patient/parent or guardian review, date and sign every 6 months)

Date	Patient Signature	D.D.S. Signature	Changes
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Sign

I understand that this information will be held in confidence and it is my responsibility to inform office of any changes in my medical status.

Patient's Signature (Parent or Guardian) _____ Date _____

I authorize the dental staff to perform the dental services my child my need.

Patient's Signature (Parent or Guardian) _____ Date _____

Dentist's Signature _____ Date _____