Koza Family Dental Care, P.C.

Adult Dental History

Previous Dentist Name _____ Phone # _____

Purpose of initial visit? _____

When was your last dental visit? _____ Last Cleaning? _____

Were x-rays taken? □ yes □ no **Do your gums bleed? □ yes □ no**

How often do you brush? _____ **How often do you floss? _____**

Have you ever had gum surgery? □ yes □ no If yes, when? _____

Have you had any teeth removed? □ yes □ no If yes, for what reason? _____
_____

Any complications or problems with previous dental treatment? □ yes □ no
If yes, please explain _____

Do you have any questions or concerns you would like to discuss with the Doctor?
If so please list _____

Do you clench or grind your teeth? □ yes □ no

Does your jaw lock or pop? □ yes □ no

Any soreness or pain in your jaw? □ yes □ no

Do you have frequent headaches? □ yes □ no

Does food get caught in your teeth? □ yes □ no

Do you have sensitive teeth? □ yes □ no

Have you had orthodontic work? □ yes □ no

Are you happy with the appearance of your smile? □ yes □ no

Do you have a TMJ history disorder/treatment? □ yes □ no

(Please Fill Out Both Sides)

Koza Family Dental Care, P.C.

Adult Medical History

Medical Doctor _____ Phone Number _____

Have you been under the care of a Physician in the last 2 years? ☐ yes ☐ no
If yes, please explain _____
_____

Current medications you are taking (please include OTC, herbal, and dietary supplements)
_____
_____

Have you been hospitalized or had any surgeries in the last 5 years? ☐ yes ☐ no
If yes, please explain _____

Have you had any ALLERGIC reaction to any medication or local anesthetic? ☐ yes ☐ no
If yes, please explain _____

Are you allergic to or had a bad reaction to Latex or Metals? ☐ yes ☐ no
If yes, please explain _____

Have you taken bone sparing medication such as Fosmax, Actonel, Boniva or Zometa?
☐ yes ☐ no If yes, for how long? _____

Do you use tobacco products? ☐ yes ☐ no How often? ____Number of years _____
Do you use Alcohol? ☐ yes ☐ no How often? _____
Do you use medical or recreational marijuana? ☐ yes ☐ no How often _____
What method _____

(Women) Are you or could you be pregnant? ☐ yes ☐ no Due Date _____

Please check all that apply to you:

☐ Heart Attack	☐ Asthma
☐ Heart Surgery	☐ Tuberculosis
☐ Heart Disease	☐ Hepatitis A, B, or C
☐ Heart Murmur	☐ Blood Thinners
☐ Chest Pains	☐ HIV Positive
☐ Congenital Heart Disease	☐ AIDS
☐ High/Low Blood Pressure	☐ Psychiatric Care
☐ Artificial Pins/Joints/Valves	☐ Liver Disease
☐ Rheumatic Fever	☐ Neurological Disorders
☐ Stroke	☐ Epilepsy or Seizures
☐ Ulcers or Stomach Trouble	☐ Fainting or Dizzy Spells
☐ Diabetes	☐ Shortness of Breath
☐ Radiation or Chemo Therapy	☐ Kidney Disease
☐ Anemia	☐ Glaucoma
☐ Hearing Problem	☐ Cancer/Tumors
☐ Sinus Problem	☐ Blood Transfusion
☐ Arthritis	☐ Alcohol or Drug Addiction

Sign: _____ Date: _____