Trademark Dental

217 N Plymouth Ave, New Plymouth, ID 83655

Patient name_____**DOB**____/____/____

Dental History: do you have or have had any of the following? Please Circle all that apply

Tooth ache/sensitivity	Periodontal Cleanings	Bad Breath
Had a negative dental experience	Wisdom teeth removed	Snore
Sleep Apnea	Orthodontic Treatment	Grind/Clench
Interested in Orthodontic Treatment	Jaw Popping/Clicking	Headaches

Discomfort or pain today?___**Y**____**N** **Interested in Headache evaluation**___**Y**___**N**

Medical History: do you have or have had any of the following? Please Circle all that apply

Alzheimer/Dementia	Anaphylaxis	Anemia
Arthritis/Rheumatism	**Artificial Joint date**__/__/___	Artificial Heart Valve
Asthma/Respiratory	Back Problems	Bleeding/Blood Issues
Blood Disease	Cancer	Chemo Therapy
Chemical Dependency	Circulation Issues	Cold Sores/Herpes
Cortisone Treatments	Diabetes	Epilepsy
Fainting	Glaucoma	Heart Condition
Hemophilia	Hepatitis	High Blood Pressure
HIV/Aids	Kidney Disease	Liver Disease
Osteoporosis	Psychiatric Care	Pacemaker
Radiation Treatment	Rheumatic Fever	Sinus Problems
Skin Rash	Sleep Apnea	Stroke
Thyroid Problems	Tobacco Use	Positive Tuberculosis

Any other medical conditions we should know about?_____

Are you Pregnant___Y___N Nursing___Y___N

Allergy to Penicillin___Y___N, Metals___Y___N, Latex___Y___N, Anesthesia___Y___N

Any other allergies_____

List Medications_____

Patient or Parent Signature_____Date____/____/____

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