GRANDE DENTAL CARE
Dr. Marcos A. Grande, DDS PLLC
General, Cosmetic, and Implant Dentistry

New Patient Dental and Medical History

Dental History

Today's Date: _____

Patient's Name: _____ Date of Birth: _____

Reason for today's visit: _____

Name of Previous Dentist: _____ City, State: _____

Phone Number: _____ Why did you leave your previous dentist? _____

Date of last dental visit: _____ Date of last dental x-rays: _____

What is the most important thing to you about your future smile and dental health? _____

What is the most important thing to you about your dental visit today? _____

On a scale of 1-10, with 10 being highest rating:

How important is your dental health to you?	1	2	3	4	5	6	7	8	9	10
Where would you rate your current dental health?	1	2	3	4	5	6	7	8	9	10
Where do you want your dental health to be?	1	2	3	4	5	6	7	8	9	10

Please circle the following that applies to you:

Sensitivity to hot or cold:	Y	N
Headaches, earaches, neck pain:	Y	N
Teeth or fillings breaking:	Y	N
Grinding or teeth clenching:	Y	N
Loose, tipped, or shifting teeth:	Y	N
Bad breath:	Y	N
Dentures:	Y	N
Partial dentures:	Y	N
Braces:	Y	N
Periodontal (gum) treatments:	Y	N

How would you describe the condition of your teeth and gums?
Please Circle: Good Fair Poor
How often do you brush? _____ Floss? _____
Do your gums bleed when you brush? Y N Floss? Y N
Do you smoke/ chew tobacco? Y N
How much? _____ For how long? _____
For women only:
Are you taking birth control? Y N
Are you pregnant? Y N Due Date: _____
Are you nursing? Y N

Medical History

Please circle any of the following problems/conditions that apply to you:

AIDS	Y	N	Dizziness	Y	N	HIV Positive	Y	N	Seizures	Y	N
Allergies (Seasonal)	Y	N	Drug Addiction	Y	N	HPV(Human Papilloma Virus)	Y	N	Sinus Problems	Y	N
Anemia	Y	N	Emphysema	Y	N	Jaundice	Y	N	Sleep Apena	Y	N
Angina (Chest Pain)	Y	N	Epilepsy	Y	N	Kidney Disease	Y	N	Snoring	Y	N
Arthritis	Y	N	Excessive Bleeding	Y	N	Liver Disease	Y	N	Stomach Problems	Y	N
Artificial Heart Valve	Y	N	Fainting	Y	N	Low Blood Pressure	Y	N	Stroke	Y	N
Artificial Joints	Y	N	Glaucoma	Y	N	Mitral Valve Prolapse	Y	N	Thyroid Disease	Y	N
Asthma	Y	N	Heart Conditions	Y	N	Nervousness	Y	N	Tuberculosis	Y	N
Blood Disease	Y	N	Heart Lesions(Congenital)	Y	N	Pacemaker	Y	N	Tumors	Y	N
Bruise Easily	Y	N	Heart Murmur	Y	N	Radiation	Y	N	Ulcers	Y	N
Cancer	Y	N	Heart Surgery	Y	N	Respiratory Problems	Y	N	Venereal Disease	Y	N
Chemotherapy	Y	N	Hepatitis _____	Y	N	Rheumatic Fever	Y	N	Other: _____		
Depression	Y	N	High Blood Pressure	Y	N	Rheumatism	Y	N	_____		
Diabetes	Y	N	High Cholesterol	Y	N	Scarlet Fever	Y	N	_____		

Are you under a physician's care? Y N If so, what's their name and what are you seeing them for? _____

Family Physician: _____ Phone Number: _____

Medications

Are you allergic or have you reacted adversely to any of the following medications?

Aspirin	Y	N	Latex	Y	N	Percodan	Y	N	Other Medication Allergies:		
Codeine	Y	N	Local Anesthetic	Y	N	Sulfa	Y	N	_____		
Darvon	Y	N	Nitrous Oxide	Y	N	Tetracycline	Y	N	_____		
Erythromycin	Y	N	Penicillin	Y	N	Valium	Y	N	_____		

What medications are you currently taking?

_____

_____

Have you ever taken these medications?

Actonel	Y	N	Boniva	Y	N	Reclast	Y	N
Aredia	Y	N	Fosamax	Y	N	Zometa	Y	N

Herbal Supplements Y N

I certify that the information provided on this from is accurate to the best of my knowledge: _____

Signature of patient or representative

___/___/___: Changes in Hx: _____ - _____ ___/___/___: Changes in Hx: _____ - _____ ___/___/___: Changes in Hx: _____ - _____

___/___/___: Changes in Hx: _____ - _____ ___/___/___: Changes in Hx: _____ - _____ ___/___/___: Changes in Hx: _____ - _____

___/___/___: Changes in Hx: _____ - _____ ___/___/___: Changes in Hx: _____ - _____ ___/___/___: Changes in Hx: _____ - _____