Warner Dentistry (Warner & Warner, PLLC)
Michael R. Warner, DDS

Phone: (360) 260-4172
Email: care@warnerdentistry.com
Website: www.warnerdentistry.com

Name: _____ ***Birthdate:*** _____ ***Today's Date:*** _____

DENTAL HISTORY

Reason for today's visit_____

When was your last dental visit?_____ Approx. Date of your last dental x-rays_____

Have you ever had any serious complications with prior dental treatment? ☐**Yes** ☐**No**

If yes, please explain:_____

Do you have concerns about the appearance of your teeth? ☐**Yes** ☐**No**

If yes, please explain:_____

Have you ever bleached your teeth? ☐**Yes** ☐**No**

What type of toothbrush do you use: ☐ ☐**Soft** ☐**Medium** ☐**Hard** ☐**Electric**

Do you have any other specific requests regarding your dental appointments?_____

*Please **circle** the answer for **each question** listed below:

1.	Are you currently in pain?	**Yes**	**No**
2.	Do you require antibiotics before dental treatment?	**Yes**	**No**
3.	Do you brush twice daily?	**Yes**	**No**
4.	Do you floss daily?	**Yes**	**No**
5.	Do use mouthwash daily?	**Yes**	**No**
6.	Do you clean your tongue?	**Yes**	**No**
7.	Do you have bad breath?	**Yes**	**No**
8.	Do your gums ever bleed?	**Yes**	**No**
9.	Are your teeth sensitive to hot, cold sweet foods or liquids?	**Yes**	**No**
10.	Does food get caught between your teeth?	**Yes**	**No**
11.	Have you ever experienced any of the following problems in your jaw:		
	Clicking	**Yes**	**No**
	Pain (joint, ear, side of face)	**Yes**	**No**
	Difficulty opening/closing	**Yes**	**No**
12.	Have you had any head, neck or jaw injuries?	**Yes**	**No**
13.	Do you have frequent headaches?	**Yes**	**No**
14.	Do you clench or grind your teeth?	**Yes**	**No**
Have you ever had:			
15.	Orthodontic Treatment (braces)?	**Yes**	**No**
16.	Oral Surgery?	**Yes**	**No**
17.	Endodontic Treatment (root canal)?	**Yes**	**No**
18.	Your bite adjusted?	**Yes**	**No**
19.	Worn a bite plate?	**Yes**	**No**
20.	Do you experience stress when you visit the dentist?	**Yes**	**No**

Other dental history/information you would like us to know

Warner Dentistry (Warner & Warner, PLLC)
Michael R. Warner, DDS

Phone: (360) 260-4172
Email: care@warnerdentistry.com
Website: www.warnerdentistry.com

Name: _____ ***Birthdate:*** _____ ***Today's Date:*** _____

MEDICAL HISTORY

A. Are you in good health? **Yes** **No**

B. Have there been any changes in your general health in the past year? **Yes** **No**
If yes, please explain: _____
_____

C. Are you under the care of a physician? **Yes** **No**
If yes, please explain: _____
_____

D. Have you ever been hospitalized for Any surgical operation or illness? **Yes** **No**
If yes, please explain: _____
_____

E. Are you currently taking any medications Including non-prescription medicine? **Yes** **No**
Please list: _____
_____

F. Have you had any abnormal bleeding? **Yes** **No**

G. Do you bruise easily? **Yes** **No**

H. Have you ever had a blood transfusion? **Yes** **No**

I. Do you use tobacco? **Yes** **No**

J. Do you use alcohol? **Yes** **No**

K. Do you have any disease, condition or problem not listed that you think I should know about: **Yes** **No**
_____
_____

J. **Are you allergic to or have you had reactions to:**

Local anesthetics like novocaine	**Yes**	**No**
Penicillin	**Yes**	**No**
Sulfa Drugs	**Yes**	**No**
Aspirin	**Yes**	**No**
Jewelry	**Yes**	**No**
Latex	**Yes**	**No**
Other Antibiotics	**Yes**	**No**
Other Allergies	**Yes**	**No**

Do you have or have you ever had, any of the following:

1. Rheumatic Fever	**Yes No**	14. Stroke	**Yes No**	27. Kidney trouble	**Yes No**
2. Heart defect/heart murmur	**Yes No**	15. Breathing problems	**Yes No**	28. Tuberculosis	**Yes No**
3. Heart trouble/heart attack	**Yes No**	16. Asthma	**Yes No**	29. Cancer	**Yes No**
4. Heart surgery	**Yes No**	17. Allergies	**Yes No**	30. Epilepsy	**Yes No**
5. Joint replacement	**Yes No**	18. Hay fever	**Yes No**	31. Anemia	**Yes No**
6. Scarlet Fever	**Yes No**	19. Hives or skin rash	**Yes No**	32. Leukemia	**Yes No**
7. Shortness of breath	**Yes No**	20. Fainting spells	**Yes No**	33. Eating Disorder	**Yes No**
8. Pacemaker	**Yes No**	21. Diabetes	**Yes No**	**Women Only:**	
9. High blood pressure	**Yes No**	22. AIDS or HIV infection	**Yes No**	34. Are you pregnant	**Yes No**
10. Low blood pressure	**Yes No**	23. Sinus trouble	**Yes No**	35. Are you nursing	**Yes No**
11. Hepatitis	**Yes No**	24. Thyroid problems	**Yes No**	36. Are you taking birth	**Yes No**
12. Jaundice	**Yes No**	25. Arthritis or Rheumatism	**Yes No**	37. control pills	
13. Liver Disease	**Yes No**	26. Acid Reflux	**Yes No**		

Other medical history/information you would like us to know

_____
_____
_____

Authorization

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of confidence, and that it is my responsibility to inform this office of any changes.

Print Name: _____ **Relationship to Patient:** _____

Signature: _____ **Date:** _____