CAROL JIN D.D.S.
FAMILY, COSMETIC AND SEDATION DENTISTRY

Guest Medical History

Guest Name:	**Today's Date:**
Physician's Name:	**Physician's Phone:**
Pharmacy:	**Pharmacy Phone:**

If female please answer the following:

Y	N	
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are you pregnant? If Yes, # of weeks _____
☐	☐	Are you nursing?

Height _____
Weight _____

Please answer the following:

Y	N	
☐	☐	Do you smoke or use tobacco?

Y	N	Conditions	Y	N	Conditions	Y	N	Conditions
☐	☐	Abnormal Bleeding	☐	☐	Drug Abuse- Present or Past	☐	☐	HIV+ AIDS
☐	☐	Allergies	☐	☐	Epilepsy	☐	☐	Mitral Valve Prolapse
☐	☐	Anemia	☐	☐	Fainting Spells	☐	☐	Pace Maker
☐	☐	Arthritis	☐	☐	Fever Blisters	☐	☐	Radiation Therapy
☐	☐	Artificial Heart Valve	☐	☐	Frequent Headaches	☐	☐	Seizures
☐	☐	Asthma	☐	☐	Glaucoma	☐	☐	Sinus Problems
☐	☐	Cancer- Chemotherapy	☐	☐	Hepatitis A	☐	☐	Snoring
☐	☐	Congenital Heart Defect	☐	☐	Hepatitis B	☐	☐	Stroke
☐	☐	Cosmetic Surgery	☐	☐	Hepatitis C	☐	☐	Thyroid Problems
☐	☐	Diabetes	☐	☐	High Blood Pressure	☐	☐	Tired during the daytime
☐	☐	Difficulty Breathing	☐	☐	Insomnia	☐	☐	Tuberculosis
☐	☐	Difficulty with sleep quality						

Y	N	Allergies	Y	N	Allergies
☐	☐	Aspirin	☐	☐	Latex
☐	☐	Codeine	☐	☐	Metals
☐	☐	Dental Anesthetics	☐	☐	Penicillin
☐	☐	Erythromycin	☐	☐	Tetracycline
☐	☐	Jewelry	Other: _____		

Medications

Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below…

2301 Camino Ramon, Suite #220, San Ramon, CA •Tel: 925-355-1122 • Fax: 888-890-9412

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Guest Dental History

Please take a few moments to answer these questions so that we may cater our services to better meet your needs:

When was the date of your last dental visit? _____

What services were performed at your last dental visit? _____

Why did you decide to change dental offices? _____

What types of dental treatment have you had done in the past?

_____

Do you feel anxious about seeing a dentist? Y N

If so, would you like to have nitrous oxide (laughing gas) at each appointment? Y N

Are you having any areas of concern? Y N

If so, please explain: _____

Do your gums bleed when you brush or floss? Y N

Do you ever find your jaw clicking or popping? Y N

Do you clench or grind your teeth? Y N

If so, have you ever had a splint or night guard made for you? Y N

Are your teeth sensitive to temperature changes? ***(circle)*** Hot Cold Sweet Pressure

Have you noticed any mouth odors or bad taste in your mouth? Y N

What changes would you make to your smile if we could easily change anything?

_____

How healthy would you like your mouth to be? ***(circle)***

Pain relief/repairs only Average The best that it can be

Is there anything else that you would like for us to know about you before your first visit?

_____

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