Teen Pre-Clinical History

BOGER DENTAL
enhancing lives & smiles

Date: ____________________

Teen's Name: ____________________

Nickname: ____________________ Social Security #: ____________________

Address: ____________________

City: ____________________ State: ________ Zip: ____________

Home phone: ____________________ Cell phone: ____________________

School: ____________________ Grade: ____________________

Date of Birth: ____________________ Age: ____________________

Names/ages of brothers/sisters: ____________________

____

Father's Name: ____________________

Social Security #: ____________________ Birthdate: ____________________

Home phone: ____________________

Business phone: ____________________

Mother's Name: ____________________

Social Security #: ____________________ Birthdate: ____________________

Home phone: ____________________

Business phone: ____________________

Whom may we thank for referring you to our office? ____________________

How do you enjoy spending your time after school? ____________________

____

DENTAL HISTORY

What was your approximate age at your first dental experience? ____________

Has your dental care been regular? o yes o no

Have you ever had: o orthodontic treatment? o oral surgery?

o root canal treatment? o clicking or popping of the jaw joint (TMJ)?

o sensitivity to heat, cold or pressure?

How do your brush your teeth? o vigorously o moderately o lightly

How often do you brush your teeth? ____________________

How often do you floss your teeth? ____________________

Do you smoke or chew tobacco? o yes o no

Are the four food groups part of your daily diet? o yes o no

If not, what type of foods do you eat? ____________________

____

(continued on other side)

DENTAL HISTORY CONTINUED

How would you rate your present dental health? 1 2 3 4 5 6 7 8 9 10 (1 = poor, 10 = good)

Why? ____

Have your past experiences in dentistry been good or bad? ______________________________

MEDICAL HISTORY

Do you feel that you are in good health? o yes o no

When was your last medical exam? Date ______________________ Year ____________

Have you ever required hospitalization or had a serious illness? o yes o no

If yes, please explain: ____

____

Are your immunizations up-to-date? o yes o no

Are you sensitive/allergic to anything? o yes o no

If yes, please explain: ____

____

Are you presently taking any medications? o yes o no

If yes, please explain: ____

Please check any of he following that apply to you:

- o Rheumatic fever
- o Heart murmur
- o Epilepsy
- o Attention disorder
- o Asthma
- o Hay fever
- o Anemia
- o Other ______________________________
- o Diabetes
- o Breathing disorders
- o Hearing impairment
- o Counseling
- o Mitral valve prolapse
- o Visual impairment

Is there any additional information that you feel would be helpful in meeting your personal needs?: ____________

____

____

Teen's Signature ______________________________ *Date* ____________

Signature ______________________________ *Date* ____________

BOGER DENTAL

enhancing lives & smiles