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Medical & Dental History Form

Patient Name: _____ (Last) _____ (First) ____ (MI)

_____ (Preferred Name)

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in fairly good health? ◯ Yes ◯ No

Within the past year, have there been any changes in your general health? ◯ Yes ◯ No

What is the date (or approximate date) of your last medical exam?

_____

_____

Your Primary Care Physician's name, address, & phone number:

_____

_____

In case of Emergency Contact- Name, Relationship & Phone number

_____

_____

_____

Pharmacy- Name, Phone Number & Address

_____

_____

Do you have heart trouble or any form of cardiovascular disease?

- ☐ Angina (chest pains) Frequency
- ☐ Heart attack
- ☐ Heart Surgery
- ☐ Pacemaker
- ☐ Bypass
- ☐ Prosthetic heart valve
- ☐ Stroke
- ☐ Congenital heart Disease
- ☐ Atherosclerosis
- ☐ Mitral valve prolapse
- ☐ Other

If there are any yes answers please explain below.

_____

_____

Please mark any of the following to indicate Yes or No response to the question:

Have you ever had complications following dental treatment? ◯ Yes ◯ No

Are you currently under the care of a physician due to a specific condition? ◯ Yes ◯ No

Have you been hospitalized within the last 5 years due to a surgery or illness? ◯ Yes ◯ No

Are you currently taking any prescription or non prescription medications? ◯ Yes ◯ No

Do you use tobacco (smoking or chewing)? ◯ Yes ◯ No

Do you have any other conditions, diseases, ect. not listed above that we should be aware of? ◯ Yes ◯ No

If you answered yes to any of the above questions, please explain:

Have you ever had a hip or other joint replacement? If yes what joint and when did it occur?

Are you allergic to or have you had any unusual reaction to any of the following medications?

☐ Penicillin	☐ Erythromycin	☐ Sulfa Drugs	☐ Other Antibiotics	☐ Codeine
☐ Aspirin	☐ Other pain medications	☐ Local anesthetics	☐ Nitrous oxide	☐ Epinephrine
☐ Latex Allergy	☐ Allergy not listed			

If yes, please list what it was and describe reaction below.

WOMEN ONLY: Are you pregnant? ◯ Yes ◯ No

If Yes, when is the due date? _____

Please indicate if you have experienced any of the following:

***Premed ***	◯ Yes ◯ No	**ADHD ***	◯ Yes ◯ No
AIDS/HIV Positive *	◯ Yes ◯ No	**Alcoholism ***	◯ Yes ◯ No
Allergies *	◯ Yes ◯ No	**Alzheimer's disease ***	◯ Yes ◯ No
Amoxicillin Allergy *	◯ Yes ◯ No	**Ampicillin Allergy ***	◯ Yes ◯ No
Anaphylaxis *	◯ Yes ◯ No	**Anemia ***	◯ Yes ◯ No
Angina *	◯ Yes ◯ No	**Arthritis/Gout ***	◯ Yes ◯ No
Artificial Joints *	◯ Yes ◯ No	**ArtificialHeartValve ***	◯ Yes ◯ No
Asthma/Resporatory *	◯ Yes ◯ No	**Bactrim Allergy ***	◯ Yes ◯ No
Blood Disease *	◯ Yes ◯ No	**Blood Transfusion ***	◯ Yes ◯ No
Breathing problem *	◯ Yes ◯ No	**Bruise easily ***	◯ Yes ◯ No
Cancer *	◯ Yes ◯ No	**Clindamycin Allergy ***	◯ Yes ◯ No
Codeine allergy *	◯ Yes ◯ No	**ColdSores/FeverBlist ***	◯ Yes ◯ No
Cough *	◯ Yes ◯ No	**Crohns Disease ***	◯ Yes ◯ No
Diabetes *	◯ Yes ◯ No	**Dizziness/Fainting ***	◯ Yes ◯ No
Drug Addiction *	◯ Yes ◯ No	**Dry Mouth ***	◯ Yes ◯ No
Epilepsy or Seizures *	◯ Yes ◯ No	**Epinepherine Allergy ***	◯ Yes ◯ No
Erythormycin Allergy *	◯ Yes ◯ No	**Excessive Bleeding ***	◯ Yes ◯ No
Fluoride Allergy *	◯ Yes ◯ No	**Frequent cough ***	◯ Yes ◯ No
Frequent Diarrhea *	◯ Yes ◯ No	**Frequent Headaches ***	◯ Yes ◯ No
Gall Bladder Removed *	◯ Yes ◯ No	**Glaucoma ***	◯ Yes ◯ No
Growths/Tumors *	◯ Yes ◯ No	**Hay Fever ***	◯ Yes ◯ No
Head Injuries *	◯ Yes ◯ No	**Heart Murmur ***	◯ Yes ◯ No
HeartDisease/Trouble *	◯ Yes ◯ No	**Hep A ***	◯ Yes ◯ No
Hep B or C *	◯ Yes ◯ No	**Herpes ***	◯ Yes ◯ No
High Blood Pressure *	◯ Yes ◯ No	**High Cholesterol ***	◯ Yes ◯ No
Hives *	◯ Yes ◯ No	**Hypoglycenia ***	◯ Yes ◯ No
Jaundice *	◯ Yes ◯ No	**Kidney Disease ***	◯ Yes ◯ No
Latex Allergy *	◯ Yes ◯ No	**Leukemia ***	◯ Yes ◯ No
Lidocaine Allergy *	◯ Yes ◯ No	**Liver Disease ***	◯ Yes ◯ No
Low Blood Pressure *	◯ Yes ◯ No	**Lung Disease ***	◯ Yes ◯ No
Migraines *	◯ Yes ◯ No	**MitralValveProlapse ***	◯ Yes ◯ No
Nickel Allergy *	◯ Yes ◯ No	**Osteoporosis ***	◯ Yes ◯ No
Pacemaker *	◯ Yes ◯ No	**Pain In Jaw Joints ***	◯ Yes ◯ No
Parkinsons disease *	◯ Yes ◯ No	**Penicillin Allergy ***	◯ Yes ◯ No
Pre Diabetic *	◯ Yes ◯ No	**Psychiatric Care ***	◯ Yes ◯ No
Radiation Treatment *	◯ Yes ◯ No	**Recent weight loss ***	◯ Yes ◯ No
Rheumatic Fever *	◯ Yes ◯ No	**Rheumatism ***	◯ Yes ◯ No
Shingles *	◯ Yes ◯ No	**Sinus Problems ***	◯ Yes ◯ No
Sleep Apnea *	◯ Yes ◯ No	**Stomach/Intestnal ***	◯ Yes ◯ No
Sulfa Allergy *	◯ Yes ◯ No	**Takes Bisphophanates ***	◯ Yes ◯ No
Thyroid Disease *	◯ Yes ◯ No	**Tonsillitis ***	◯ Yes ◯ No
Tuberculosis *	◯ Yes ◯ No	**Tylenol Allergy ***	◯ Yes ◯ No
Ulcers *	◯ Yes ◯ No	**Venereal Disease ***	◯ Yes ◯ No
Vicodin Allergy *	◯ Yes ◯ No		

Please list ALL prescription medications or supplements currently being taken:

What is the reason for your dental visit today?

When was your last visit to the dentist (if to a different office)?

What was done on your last dental visit (if to a different office)?

Prior Dentist's name, address, & phone number:

How frequently do you brush your teeth?

◯ 3 (+) a day ◯ Twice a day ◯ Once a day ◯ Weekly ◯ Seldom

How frequently do you floss your teeth?

◯ 1 (+) a day ◯ 2 - 6 weekly ◯ 1 - 6 monthly ◯ Seldom ◯ Never

Have you ever had any injury, pain or soreness from your jaw joint? (TMJ dysfunction) ◯ Yes ◯ No

Have you ever had orthodontic treatment? ◯ Yes ◯ No

Have you ever had and chronic head, neck or back problems? ◯ Yes ◯ No

Please mark any of the following to indicate Yes in response to the question:

☐ Do your gums bleed when you brush or floss?

☐ Do your teeth experience sensitivity to cold or hot temperatures?

☐ Are any of your teeth currently causing you pain?

☐ Do you grind your teeth (either consciously or during sleep)?

☐ Are any of your teeth loose, or are you concerned about any teeth loosening?

☐ Do you currently have any dental implants, dentures, or partials?

If you could change anything about your mouth, teeth, or smile, what would it be?

☐ **To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next detal appointment without fail.**

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian:

Signature _____ _____

Date

Relationship to Patient:

Response Date: _____