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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 & phone number:

_____

_____

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

☐ Have you ever had complications following dental treatment?

☐ Are you currently under the care of a physician due to a specific condition?

☐ Have you been hospitalized within the last 5 years due to a surgery or illness?

☐ Do you use tobacco (smoking or chewing)?

☐ Do you require the use of corrective lenses (contacts or glasses)?

☐ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

If any of the previous questions are marked, please explain:

_____

_____

Please indicate if you have experienced any of the following:

- [ ] Acid Reflux
- [ ] ADHD
- [ ] Alcohol Addiction
- [ ] Allergies
- [ ] Allergy - Aspirin
- [ ] Allergy - Codeine
- [ ] Allergy - Erythro
- [ ] Allergy - Hay Fever
- [ ] Allergy - Latex
- [ ] Allergy - Other
- [ ] Allergy - Penicillin
- [ ] Allergy - Sulfa
- [ ] Alzheimer's/Dementia
- [ ] AMD- muscular Degena
- [ ] Anemia
- [ ] Arthritis
- [ ] Artific. Heart Valve
- [ ] Artificial Joints
- [ ] Aspirin Allergy
- [ ] Asthma
- [ ] Atrial Fibrillation
- [ ] Autoimmune disorder
- [ ] Back Problems
- [ ] Benzocaine/Topical
- [ ] Blood Disease
- [ ] Cancer
- [ ] Ceclor Allergy
- [ ] Celiac Disease
- [ ] Cerebral Palsey
- [ ] Cholesterol
- [ ] Chronic Fatigue Synd
- [ ] Ciprofloxacin
- [ ] Clindamysin
- [ ] Colon
- [ ] COPD
- [ ] Corticosteroids
- [ ] Crohn's Disease
- [ ] CVID
- [ ] Dairy Allergy
- [ ] Depression
- [ ] Diabetes
- [ ] Dizziness
- [ ] Drug Addiction
- [ ] Emphysema
- [ ] Epilepsy
- [ ] Epinephrine Allergy
- [ ] Erythromycin
- [ ] Excessive Bleeding
- [ ] Factor V Leiden
- [ ] Fluoride
- [ ] Gastric Sleeve
- [ ] Glaucoma
- [ ] Gluten Allergy
- [ ] Gout
- [ ] Graves Disease
- [ ] Hashimoto's Disease
- [ ] Head Injuries
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Heart Problems
- [ ] Hepatitis
- [ ] Herpes
- [ ] High Blood Pressure
- [ ] High Cholesterol
- [ ] HIV
- [ ] HPV
- [ ] Hyperhidrosis
- [ ] Hysterectomy
- [ ] IBS
- [ ] Jaundice
- [ ] Kidney Disease
- [ ] Lactose Intolerant
- [ ] Liver Disease
- [ ] Low Blood Pressure
- [ ] lung disease
- [ ] Mental Disorders
- [ ] Migraines
- [ ] Mitro-Valve Pro
- [ ] MS
- [ ] Nervous Disorders
- [ ] NO ADVIL
- [ ] No Ibuprofen
- [ ] Pacemaker
- [ ] Parkinsons
- [ ] Pregnancy
- [ ] Pre-Med - Amox
- [ ] Pre-Med - Clind
- [ ] Pre-Med - Other
- [ ] Prozac
- [ ] Pulmonary
- [ ] Radiation Treatment
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] Seizures
- [ ] Sinus Problems
- [ ] Sjogren's
- [ ] Sleep Apnea
- [ ] Smoker
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Tetracycline
- [ ] Tetracycline
- [ ] Thyroid Problems
- [ ] TMJ
- [ ] Tourette Syndrom
- [ ] Tramadol
- [ ] Tree Nuts
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Ulcers
- [ ] Varstatin
- [ ] Vertigo

Do you have any other health issues or allergies?

Please list any surgeries and/or hospital stays along with date and any follow-up recommendations:

Are you currently taking any medications? ◯ Yes ◯ No

Please list any prescription/non-prescription/supplement medications that you are currently taking, including dosage information?

WOMEN ONLY: Are you pregnant? ◯ Yes ◯ No

If Yes, when is the due date? _____

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

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 any of the previous questions are marked, please explain:

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 consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

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: _____