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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:

_____

_____

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

☐ 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?
☐ Are you currently taking any prescription or non-prescription medications?
☐ Do you use tobacco (smoking or chewing)?
☐ 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:

_____

_____

_____

_____

WOMEN ONLY: Are you pregnant? ◯ Yes ◯ No

If Yes, when is the due date? _____

Please indicate if you have experienced any of the following:

☐ Allergies	☐ Sulfa Allergy	☐ Penicillin Allergy	☐ Latex Allergy	☐ Hay Fever	☐ Hives
☐ Blood Disease	☐ Anemia	☐ Sickle Cell Disease	☐ Hemophilia	☐ Heart Disease	☐ Heart Murmur
☐ Heart Failure/Attack	☐ Mitral Valve Prolapse	☐ High Blood Pressure	☐ Blood Transfusion	☐ Excessive Bleeding	☐ Angina Pectoris
☐ Kidney Disease	☐ Liver Disease	☐ Hepatitis A	☐ Hepatitis B	☐ Respiratory Problems	☐ Asthma
☐ Emphysema	☐ Tuberculosis	☐ Stomach Problems	☐ Ulcers	☐ Cancer	☐ Radiation
☐ Chemotherapy	☐ Tumors	☐ Heart Surgery	☐ Pacemaker	☐ Aritificial Heart Valve	☐ Artificial Joints
☐ PREMED	☐ Arthritis	☐ Rheumatism	☐ Venereal Disease	☐ HIV Positive	☐ A.I.D.S.
☐ Head Injuries	☐ Vertigo	☐ Fainting	☐ Nervous Disorders	☐ Epilepsy	☐ Diabetes
☐ Thyroid Problems	☐ Jaundice	☐ Glaucoma	☐ Drug Addiction	☐ Sinus Problems	☐ Chronic Cough
☐ Cold Sores/Blisters	☐ Other				

Do you have any other health issues or allergies?

_____

_____

_____

Dental Information

Previous dentist and phone number

_____

_____

When were last x-rays taken? _____

How long has it been since your last dental treatment? _____

What was done at this time? _____

What is the reason for your dental visit today?

_____

_____

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 been treated for gum disease? ◯ Yes ◯ No

If answered yes to above, how long since last deep cleaning (SRP)? _____

Have you ever had braces? ◯ Yes ◯ No

Have you ever had a root canal? ◯ Yes ◯ No

Do you clench or grind your teeth? ◯ 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 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:

_____

_____

_____

What do you need to be more comfortable or relaxed during dental visits? (N20)

_____

_____

If you could change anything about your smile, what would it be? (cosmetic/whitening)

☐ **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:

_____

_____

Employee initials: _____

Response Date: _____