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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:

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?
- ☐ Are you currently taking any prescription or non-prescription medications?
- ☐ 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:

WOMEN ONLY: Are you pregnant? ◯ Yes ◯ No

If Yes, when is the due date? _____

For All Patients
Please indicate if you have experienced any of the following:

- ☐ *Pre-Medication
- ☐ Allergy - Aspirin
- ☐ Allergy - Penicillin
- ☐ Anemia
- ☐ Blood Disease
- ☐ Contraceptive Use
- ☐ Emphysema
- ☐ Gastro-Intestinal
- ☐ Hay Fever
- ☐ Heart Disease
- ☐ Hepatitis C
- ☐ Kidney Disease
- ☐ Morphine
- ☐ Pregnancy
- ☐ Rheumatism
- ☐ STD
- ☐ TMJ
- ☐ Wheelchair
- ☐ *See Patient Notes
- ☐ Allergy - Codeine
- ☐ Allergy - Sulfa
- ☐ Arthritis
- ☐ Cancer
- ☐ COPD
- ☐ Epilepsy
- ☐ GERD
- ☐ HBP
- ☐ Heart Murmur
- ☐ HIV+ (AIDS)
- ☐ LBP
- ☐ Multiple Sclerosis
- ☐ Radiation Treatment
- ☐ Rheumatoid Arthritis
- ☐ Stomach Problems
- ☐ Tuberculosis
- ☐ Acid Reflux
- ☐ Allergy - Iodine
- ☐ Allergy-Erythromicin
- ☐ Artificial Joints
- ☐ Codeine
- ☐ Diabetes
- ☐ Excessive Bleeding
- ☐ Glaucoma
- ☐ Head Injury
- ☐ Hepatitis A
- ☐ Hives
- ☐ Liver Disease
- ☐ Nervous Disorders
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Tumors
- ☐ Allergy - *See Notes
- ☐ Allergy - Latex
- ☐ Allergy-Local Anesth
- ☐ Asthma
- ☐ Cold Sores
- ☐ Dizziness/Fainting
- ☐ Excessive Bruising
- ☐ Hard To Freeze
- ☐ Hearing Disabled
- ☐ Hepatitis B
- ☐ Jaundice
- ☐ Mental Disorders
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Skin Rash
- ☐ Thyroid Disease
- ☐ Ulcers

Do you have any other health issues or allergies?

_____

_____

What is the reason for your dental visit today?

☐ Cleaning and Examination ☐ Sensitivity and/or Pain

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:

_____

_____

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 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).

I authorize consent to treatment.

Signature of patient, parent, or guardian:

Signature _____ _____

Date

Relationship to Patient:

Response Date: _____