

**PATIENT INFORMATION**

DATE \_\_\_\_\_

NAME \_\_\_\_\_  
LAST FIRST MIDDLE  MALE  FEMALE  OTHER \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_

ADDRESS \_\_\_\_\_  
STREET APT. # CITY STATE ZIPBIRTHDATE \_\_\_\_\_ TELEPHONE \_\_\_\_\_  
MONTH DAY YEAR HOME WORK CELL E-MAIL

NAME OF EMPLOYER \_\_\_\_\_ ADDRESS \_\_\_\_\_

PERSON RESPONSIBLE FOR ACCOUNT - PLEASE CHECK ONE:  PATIENT  GUARDIAN  SPOUSE  FATHER  MOTHER**PERSON TO CONTACT IN CASE OF EMERGENCY**

Name \_\_\_\_\_

Has any member of your family ever been treated in our office?

 Yes  No

Address \_\_\_\_\_

Whom may we thank for referring you to our office?

City/State/ZIP \_\_\_\_\_

Telephone # \_\_\_\_\_

**AUTHORIZATION**

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer

X \_\_\_\_\_  
Signature of Patient or Responsible Party

Date \_\_\_\_\_

# DENTAL AND MEDICAL HISTORY FORM

**PATIENT NAME:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

Primary reason for this appointment:       Examination       Emergency       Consultation

## Dental History

- Do you have a specific dental problem? Describe: Yes  No
- Do you have dental examinations on a routine basis? Last visit: Yes  No
- Do you think you have active decay or gum disease? Yes  No
- Do you brush and floss on a routine basis? Discuss: Yes  No
- Do your gums ever bleed? Discuss: Yes  No
- Do you like your smile? Why? Yes  No
- Does food catch between your teeth? Any loose teeth? Yes  No
- Do you have clicking/popping/discomfort in jaw? Do you brux or grind? Yes  No
- Have your past dental office experiences always been positive? Yes  No
- Do you smoke or chew? Any sores or growths in your mouth? Discuss: Yes  No
- Name of previous dentist (optional):       Date of last full mouth X-rays: \_\_\_\_\_

## Medical History

- Are you under a physician's care now? Why? \_\_\_\_\_ Who? \_\_\_\_\_ Phone: \_\_\_\_\_ Yes  No
- Have you ever been hospitalized or had a major operation? Discuss: \_\_\_\_\_ Yes  No
- Have you ever had a serious injury to your head or neck? Discuss: \_\_\_\_\_ Yes  No
- Are you taking any medications incl. aspirin, vitamins, herbals, pills or drugs? List: \_\_\_\_\_ Yes  No
- Are you allergic to any medications or substances? Yes  No
- Allergies – check all that apply:**     Aspirin     Penicillin     Codeine     Acrylic     Metal     Latex     Rubber     Milk     Other \_\_\_\_\_ Yes  No
- Women (check all that apply):**     Pregnant/trying to get pregnant       Nursing      Taking oral contraceptives

## Do you now have or have you ever had any of the following? (\*Call prior to appointment if starred)

- |   |   |   |   |  |
|---|---|---|---|--|
| <input type="checkbox"/> Heart Disease/Surgery*       | <input type="checkbox"/> Anemia                   | <input type="checkbox"/> Radiation Therapy          | <input type="checkbox"/> Hepatitis B or C             | <input type="checkbox"/> Cold Sores              |
| <input type="checkbox"/> Heart Murmur or Defect*      | <input type="checkbox"/> Excessive Bleeding       | <input type="checkbox"/> Cancer                     | <input type="checkbox"/> Night Sweats                 | <input type="checkbox"/> Herpes                  |
| <input type="checkbox"/> Irregular Heart Beat/Murmur  | <input type="checkbox"/> Sickle Cell Disease      | <input type="checkbox"/> Chemotherapy               | <input type="checkbox"/> Yellow Jaundice              | <input type="checkbox"/> Stroke                  |
| <input type="checkbox"/> Angina/Chest Pain            | <input type="checkbox"/> Hemophilia               | <input type="checkbox"/> Osteoporosis               | <input type="checkbox"/> Kidney Problems              | <input type="checkbox"/> Convulsions             |
| <input type="checkbox"/> Heart Attack/Failure         | <input type="checkbox"/> Leukemia                 | <input type="checkbox"/> Bisphosphonates            | <input type="checkbox"/> Renal Dialysis               | <input type="checkbox"/> Epilepsy or Seizures    |
| <input type="checkbox"/> Congenital Heart Disorder*   | <input type="checkbox"/> Recent Blood Transfusion | <input type="checkbox"/> Osteonecrosis of Jaw       | <input type="checkbox"/> Arthritis/Gout               | <input type="checkbox"/> Fainting or Dizziness   |
| <input type="checkbox"/> Mitral Valve Prolapse*       | <input type="checkbox"/> Swelling of Limbs        | <input type="checkbox"/> Thyroid Disease            | <input type="checkbox"/> Rheumatism                   | <input type="checkbox"/> Glaucoma                |
| <input type="checkbox"/> Scarlet Fever                | <input type="checkbox"/> Lung Disease             | <input type="checkbox"/> Parathyroid Disease        | <input type="checkbox"/> Pain in Jaw Joints           | <input type="checkbox"/> Tumors or Growths       |
| <input type="checkbox"/> Rheumatic Fever*             | <input type="checkbox"/> Breathing Problem        | <input type="checkbox"/> Stomach/Intestinal Disease | <input type="checkbox"/> Cortisone Medicine           | <input type="checkbox"/> Nervousness             |
| <input type="checkbox"/> Artificial Heart Valve*      | <input type="checkbox"/> Shortness of Breath      | <input type="checkbox"/> Ulcers                     | <input type="checkbox"/> Artificial Joint*            | <input type="checkbox"/> Psychiatric Care        |
| <input type="checkbox"/> Heart Pace Maker*            | <input type="checkbox"/> Frequent Cough           | <input type="checkbox"/> Recent Weight Loss         | <input type="checkbox"/> Sexually Transmitted Disease | <input type="checkbox"/> Alzheimer's Disease     |
| <input type="checkbox"/> Pulmonary Shunt*             | <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Frequent Diarrhea          | <input type="checkbox"/> AIDS                         | <input type="checkbox"/> Parkinson's Disease     |
| <input type="checkbox"/> High Blood Pressure          | <input type="checkbox"/> Sinus Trouble            | <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> HIV Positive                 | <input type="checkbox"/> Allergies (Pollen/Dust) |
| <input type="checkbox"/> Low Blood Pressure           | <input type="checkbox"/> Bloody Sputum            | <input type="checkbox"/> Excessive Thirst           | <input type="checkbox"/> Genital Herpes               | <input type="checkbox"/> Hives or Rashes         |
| <input type="checkbox"/> Bacterial Endocarditis*      | <input type="checkbox"/> Tuberculosis             | <input type="checkbox"/> Hypoglycemia               | <input type="checkbox"/> Drug Addiction/Alcoholism    | <input type="checkbox"/> Need Premedication*     |
| <input type="checkbox"/> Unexplained Fever            | <input type="checkbox"/> Emphysema                | <input type="checkbox"/> Liver Disease              | <input type="checkbox"/> Tattoo/Body Piercing         | <input type="checkbox"/> Cochlear Implants       |
| <input type="checkbox"/> Bruise Easily/Blood Disorder | <input type="checkbox"/> Hay Fever                | <input type="checkbox"/> Hepatitis A (Infectious)   | <input type="checkbox"/> Sleep Apnea                  |  |
| <input type="checkbox"/> Coronary Stent*              |   |   | <input type="checkbox"/> Fever Blisters               |  |

- Have you ever had any other serious illness not checked above? Discuss: Yes  No
- Do you wish to talk to the dentist privately about any problem? Yes  No

X \_\_\_\_\_ Date \_\_\_\_\_  
PATIENT SIGNATURE (PARENT OR GUARDIAN)

**Reviewed By Doctor** \_\_\_\_\_ **Date** \_\_\_\_\_ **BP** \_\_\_\_\_ **Pulse** \_\_\_\_\_

**Significant Findings:** \_\_\_\_\_

## Medical Updates

I have read my MEDICAL HISTORY and confirm that it adequately states past and present conditions.

Date	Changes	Patient Signature	BP	Pulse	Reviewed By
_____	_____	X _____	_____	_____	Dr. _____
_____	_____	X _____	_____	_____	Dr. _____
_____	_____	X _____	_____	_____	Dr. _____
_____	_____	X _____	_____	_____	Dr. _____
_____	_____	X _____	_____	_____	Dr. _____