Medical/Dental History

PERSONAL HISTORY

Date:_____

Name:_____Date of Birth:_____Gender : M F

Address:_____City:_____ _____State_____Zip Code:_____

Home Phone:_____Cell Phone:_____Business Phone:_____

Email: _____Height_____Weight_____Marital Status: _____

Employed by:_____Position:_____

Address:_____City:_____State_____

What is the best way to confirm your appointment?

Home Phone☐ Business Phone:☐ E-Mail:☐ Cell Phone☐ Text:☐ (Mark One)

Name of Spouse: _____Employed by:_____Phone:_____

Dentist's Name:_____Address:_____Phone:_____

Referred by: _____

Physician's Name:_____Date of Last Physical Exam_____Reason:_____

Emergency Information:

Contact Name:_____Address_____

Relationship:_____Phone: _____

Have other family members been treated in our office? Y or N

Name of family member(s):_____

PRIMARY DENTAL INSURANCE INFORAMTION:

Name of Insured: _____Relationship to Patient:_____

Birthdate:_____SS#/ID#_____Date Employed:_____

Name of Employer_____Work Phone:_____

Address of Employer_____City:_____State:_____

Insurance Company Name:_____Group#:_____Union Local#_____

Insurance Company Address:_____City:_____State:_____Zipcode:_____

Do you have a secondary dental insurance plane? Y or N If yes, complete the following:

Name of Insured: _____Relationship to Patient:_____

Birthdate:_____SS#/ID#_____Date Employed:_____

Name of Employer_____Work Phone:_____

Address of Employer_____City:_____State:_____

Insurance Company Name:_____Group#:_____Union Local#_____

Insurance Company Address:_____City:_____State:_____Zipcode_____

MEDICAL HISTORY:

List medications that you are presently taking and for what medical condition (i.e. Novasc-High Blood Pressure)

Do you have Osteoporosis? Y or N Has your Osteoporosis been treated with medication? Y or N

If so, list **ANY/ALL** medications:_____

How long on current medication? _____

Do you smoke? Y or N If yes, complete the following: How much?_____For how long?_____

Do you take aspirin daily? If yes, _____mg Do you have a latex allergy? Y or N

Do you take antibiotics routinely prior to dental care? Y or N If yes, with what antibiotic_____

List all medications you are allergic to (i.e. Codeine, Aspirin, Penicillin, Ibuprofen,

Are you on any pain management program? Y or N If so, list all programs, medications and the prescribing doctor's name:

Circle any of the following conditions that you have had or have at present.

Diabetes	Hormone Replacement Therapy	Blood Transfusion
Heart Failure	Emphysema	HIV Positive
Heart Disease or Attack	Cough	AIDS
Angina Pectoris	Tuberculosis (TB)	Hepatitis A (Infectious)
High Blood Pressure	Asthma	Hepatitis B (Serum)
Heart Murmur	Hay Fever	Hepatitis C
Rheumatic or Scarlet Fever	Sinus Trouble	Liver Disease
Congenital Heart Lesions	Allergies or Hives	Yellow Jaundice
Mitral Valve Prolapse	Thyroid Disease	Hemophilia
Artificial Heart Valve	Radiation Therapy	Anemia
Heart Pacemaker	Chemotherapy	Cold Sores
Heart Surgery	Arthritis	Canker Sores
Artificial Joint or Limb Replacement	Rheumatism	Crohns Syndrome
Lupus	Fibromyalgia	Sjogrens Syndrome
Sexually Transmitted Disease(s)	Organ Transplant	Bruise Easily
Stroke	Kidney Trouble	Sickle Cell Disease
Cataracts	Pain in Jaw Joints	Eating Disorders
Glaucoma	Cortisone Medicine	Nervousness
Reflux Disease	Ulcers	Psychiatric Treatment
Epilepsy or Seizures	Fainting or Dizzy Spells	Memory Issues
Multiple Sclerosis (MS)	Sleep Apnea/Mouth Breathing	

Cancer – Describe_____

Other conditions not listed: _____

_____

Circle:

Are you having pain or discomfort at this time?_____ Yes or No

Do you feel very nervous about having dental treatment?_____ Yes or No

Have you ever had a bad experience in the dental office?_____ Yes or No

Have you been a patient in the hospital for a major illness in the past two years_____ _____ Yes or No

Have you been under the care of a medical doctor in the past two years_____ Yes or No

Have you ever had any excessive bleeding requiring special treatment?_____ Yes or No

When you walk up stairs or take a walk, do you have to stop because of pain in your chest,
shortness of breath or because you are very tired?_____ Yes or No

Do your ankles swell during the day?_____ Yes or No

Do you use more than 2 pillows to sleep?_____ Yes or No

Have you lost or gained 10 pounds in the past year?_____ Yes or No

Do you ever wake up from sleep short of breath?_____ Yes or No

Are you on a special diet?_____ Yes or No

Have you been out of the United States in the last two years?_____ Yes or No

Women

Are you pregnant?_____ Yes or No

Are you taking any birth control_____ Yes or No

Do you anticipate becoming pregnant?_____ Yes or No

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if any my medicines change, I will inform the doctor of dentistry at the next appointment without fail.

Professional care is provided to you, our patient, and it is your responsibility to pay any balance incurred regardless of insurance coverage.

Date_____ Signature of Patient, Parent or Guardian_____

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