Date: _____

Medical/Dental History

PERSONAL HISTORY

Name: _____Date of Birth: _____Gender: M☐F☐

Address: _____City:_____ _____State:_____Zip Code: _____

Home Phone: _____Cell Phone: _____Business Phone: _____

What is the best way to confirm your appointment? Check all that applies: Home Phone☐ Business Phone☐ E-Mail☐ Cell Phone☐ Text☐

Email: _____Height:_____Weight:_____Marital Status: _____

Employed by: _____ Position: _____

Address: _____City:_____State:_____

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#:_____

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, completes 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 ***ever*** been treated with medication? Y☐or N☐ If so, for how long _____

Please provide any and all medication for your Osteoporosis:_____

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

Do you take aspirin daily? If yes, _____mg or N☐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:_____

Pharmacy Preference:_____

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