Medical History

Patient Name**:** **D.O.B.**

Please Circle Yes or No for All Questions

- Do you have any medical conditions? Yes No
  * If Yes, please explain:_____
- Are you taking any prescription, non-prescription or herbal medications? Yes No
  * If Yes, please list your medications and dosage:_____

  _____
- Have you ever had an **adverse reaction** or complication to dental treatment? Yes No
  * If Yes please explain:_____
- Do you have an allergy or adverse reaction to any medications? Yes No
  * If Yes, please explain: _____
- Please check the following medications to which you are allergic or have had adverse reactions.
  ☐ Novocaine, Lidocaine, Articaine, Mepivicaine ☐ Aspirin/non-steroidal anti-inflammatory Meds
  ☐ Latex ☐ Penicillin or Other Antibiotics _____
  ☐ Narcotic Pain Medications (Codeine, Percocet) ☐ Epinephrine (Adrenalin)
- Have you been hospitalized in the past 5 years? Yes No
  * If Yes, please explain:_____
- Are you taking, have you ever taken, or will you be taking any osteoporosis/bone loss prevention medications? Yes No
- Do you Smoke or use other Tobacco Products? What/How much? _____ Yes No
- Have you ever had an **artificial joint** placed (knee, hip, shoulder, elbow, etc)? Yes No
- Have you ever had infective endocarditis? Yes No
- **Women:**
  * Are you or do you think you could be pregnant? Yes No
  * Are you nursing? Yes No

Please Circle Yes or No to Indicate Which of the Following You Have Had

Heart (Surgery, Disease, Attack, Angina)	Yes	No	Respiratory Disorder or Disease	Yes	No
Heart Murmur	Yes	No	Asthma	Yes	No
Rheumatic Fever	Yes	No	Tuberculosis	Yes	No
Artificial Heart Valve	Yes	No	Allergies	Yes	No
Heart Stent	Yes	No	Cancer (type)	Yes	No
Stroke	Yes	No	Liver Disorder or Disease	Yes	No
Blood Pressure (High or Low)	Yes	No	Hepatitis A, B, C (circle)	Yes	No
Arthritis	Yes	No	H.I.V. / A.I.D.S.	Yes	No
Artificial Joints (Hip ,Knee, etc)	Yes	No	Blood Disorder or Disease (Anemia)	Yes	No
Kidney Disorder or Disease	Yes	No	Abnormal Bleeding	Yes	No
Stomach Ulcer	Yes	No	Epilepsy or Seizures	Yes	No
Diabetes Type I or Type II (circle)	Yes	No	Mood Disorders	Yes	No
Thyroid Disorder or Disease	Yes	No	Psychiatric/Psychological Care	Yes	No

- Do you have or have you had any disease, condition, or problem not listed? _____

I understand the above information is necessary to provide me with safe and efficient dental care. Should further information be needed, you have my permission to contact the respective health care provider who may release such information to you. I will notify the doctor or his staff of any changes in my health or medications.

Patient / Guardian Signature_____ Date _____

Dentist Signature _____ Date _____

Dental History

- Do you have any dental problems or concerns? Yes No
  - If yes, please explain: _____
    _____
- Have you ever had a serious injury to your mouth or head? Yes No
  - If yes please explain: _____
    _____
- Do you wear dentures or partials? Yes No
- Are you happy with your smile? Yes No
  - If not, what would you like to change? _____
- Does food tend to become caught in between your teeth? Yes No
  - If yes, please explain: _____
- Do you feel nervous about dental treatment? Yes No
  - If yes, what are your concerns? _____
- Have you ever had an upsetting dental experience? Yes No
  - If Yes, please explain: _____
- Date of Last Dental Visit _____
- What was done at your last dental visit? _____
- How often do you have dental examinations? _____
- What do you do every day to care for your teeth, gums and mouth?_____
  _____
- Previous Dentist's Name_____
- Address _____ State _____ Zip _____

Are You Experiencing:						
Tooth Sensitivity to Hot or Cold	Yes	No		Clenching, Grinding or Tapping your Teeth while Awake or Asleep	Yes	No
Tooth Sensitivity to Sweets	Yes	No		Clicking or Popping of your Jaw	Yes	No
Tooth Sensitivity to Biting or Chewing	Yes	No		Pain in the Jaw Joint, Ear, or Side of Face	Yes	No
A Sharp, Short-lived Tooth Pain to Chewing "Just the Wrong Way"	Yes	No		Difficulty Opening or Closing your Mouth	Yes	No
Do your gums bleed?	Yes	No		Frequent Headaches	Yes	No
Is your mouth dry?	Yes	No		Frequently Painful Neck and/or Shoulders	Yes	No
Have You Ever Had:						
Orthodontics (Braces) (Retainer)	Yes	No		Periodontal (Gum) Treatment	Yes	No
Oral Surgery (Extractions, Jaw Surgery)	Yes	No		Night Guard or TMJ Treatment Appliance	Yes	No

I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, insurance billing, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available upon request.
I agree to be responsible for the payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. If required, I also understand a check of my credit history may be made.

Patient's Signature _____ Date: _____

Parent/Responsible Party's Signature _____

Notes:

Patient Information

Patient's Name _____ Prefers to be called?

_____

Patient's Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone: _____

E-mail Address _____ Patient's Birth Date: ____/____/____

Patient's preferred means of contact (circle all that apply) Text Message Email Phone call

Patient's S.S. # _____ Male ☐ Female☐

Employer_____ Occupation _____

Business Address _____ City _____ State _____ Zip _____

Business Phone _____

How did you hear about our dental practice? _____

Dental Insurance Information

Subscriber _____ Subscriber Birth Date: ____/____/____

Subscriber Relationship to Patient _____ Insurance Company _____

Group # _____ Subscriber I.D.# _____

Subscriber S.S.#_____

Secondary Dental Insurance Information

Subscriber _____ Subscriber Birth Date: ____/____/____

Subscriber Relationship to Patient _____ Insurance Company _____

Group # _____ Subscriber I.D.#_____

Subscriber S.S.#_____

Person Financially Responsible for the Account

(Leave blank if patient)

Name _____ Birth Date: ____/____/____

Relationship to Patient _____ S.S. # _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone_____