MEDICAL-DENTAL HISTORY

Name (Mr., Ms., Mrs.): _____ What should we call you? _____

Address: _____ Date of birth: _____

City: _____ Zip Code: _____ Age: _____

Home Phone: _____ Occupation: _____

Cell Phone: _____ Employer: _____

Work Phone: _____ E-Mail: _____

Referred by: _____ Social Security Number: _____

Name of Dentist:_____ Hobbies: _____

Name of Family Physician: _____ Dental Insurance: ☐ Yes ☐No

Name of Cardiologist: _____ Emergency Contact: _____

Name of Pain Management Physician: _____

Where have you heard about us? Please check all that apply:

☐ Television ☐ Friend ☐ Internet ☐ Sign ☐ Radio ☐ Newspaper

☐ Referring Dentist: _____

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1. Are you currently under the care of a physician? ☐ Yes ☐No

2. Please list dates and reasons for hospitalizations_____

_____

3. Please list allergies to drugs or medications_____

_____

Have you ever been treated for the following conditions:

4. Rheumatic fever, rheumatic heart disease, heart murmur or congenital heart disease? If yes, please specify._____

_____

5. Heart trouble, heart attack, angina, heart surgery, a pacemaker, or irregular beats? If yes, please specify. _____

_____

Have you ever or are you currently been treated for the following conditions:

6. Excessive bleeding: ☐ Yes ☐ No List medications: _____

7. Breathing problems, asthma, tuberculosis, hay fever: ☐ Yes ☐ No List medications: _____

8. Cancer, x-ray treatment, or chemotherapy: ☐ Yes ☐ No List medications: _____

9. Hepatitis, jaundice, or liver disease: ☐ Yes ☐ No List medications: _____

10. Kidney problems or renal dialysis: ☐ Yes ☐ No List medications: _____

11. Venereal disease, STD's or AIDS: ☐ Yes ☐ No List medications: _____

12. A stroke, convulsions, or fainting spells: ☐ Yes ☐ No List medications: _____

13. Tumors or growths: ☐ Yes ☐ No List medications: _____

14. Arthritis or rheumatism: ☐ Yes ☐ No List medications: _____

15. High cholesterol: ☐ Yes ☐ No List medications: _____

16. High blood pressure: ☐ Yes ☐ No List medications: _____

17. Diabetes: ☐ Yes ☐ No List medications: _____

If yes: ☐Type 1 ☐ Type 2 When was your last AIC test result: _____ How often are you tested: _____

Do you take any of the following:

18. Pain medications: ☐ Yes ☐ No List medications: _____

19. Anxiety or mind altering medications: ☐ Yes ☐ No List medications: _____

20. Sleep medications: ☐ Yes ☐ No List medications: _____

21. Osteoporosis medications: ☐ Yes ☐ No List medications: _____

22. Aspirin and/or blood thinners: ☐ Yes ☐ No If yes, dose:
_____

23. Vitamin or herbal supplements: ☐ Yes ☐ No List medications: _____

24. Please list any other medications you are taking and for what reason: _____
_____

25. Have you ever had a serious injury to your head or neck? If yes, describe. _____
_____

26. Do you smoke? ☐ Yes ☐ No If yes, describe type and frequency: _____

27. For women: Are you pregnant or breastfeeding? _____

DENTAL HISTORY

28. What would you like done for your mouth? _____

29. Are you satisfied with the appearance of your teeth? _____

30. Are you satisfied with your ability to chew? _____

31. Does food catch between your teeth: ☐ Yes ☐ No

32. Are any of your teeth sensitive to heat, cold, or pressure: ☐ Yes ☐ No

33. Do you snore: ☐ Yes ☐ No

34. Have you been diagnosed with sleep apnea: ☐ Yes ☐ No

35. Do you get headaches or migraines: ☐ Yes ☐ No

36. Do you grind your teeth or clench your jaws: ☐ Yes ☐ No

37. Do you have pain or clicking in the jaw joint around your ear: ☐ Yes ☐ No

38. Have your jaw muscles ever been sore: ☐ Yes ☐ No If yes, please describe_____

39. Are there any sores or growths in your mouth: ☐ Yes ☐ No

40. Do any of your teeth ache: ☐ Yes ☐ No

In respect to previous dental treatment have you:

41. Ever had a bad dental experience: ☐ Yes ☐ No

42. Had an allergic reaction: ☐ Yes ☐ No If yes, please describe: _____

43. Had abnormal bleeding: ☐ Yes ☐ No

44. Other complications during or following dental treatment: ☐ Yes ☐ No If yes, please describe:_____

NOTE: A change in your health status should be reported to the office at the earliest possible time.

To the best of my knowledge, the above questions have been accurately answered.

Permission to release health information:
I grant the right to the dentist to release health information obtained from me, and information about my dental treatment, to third party payors and/or health care practitioners.

Person completing this form:

_____ _____ _____
Signature Printed Name Date

If other than patient, indicate relationship: _____