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: _____

Name of Physician: _____ Social Security Number: _____

How did you hear about us: _____ Dental Insurance: ☐ Yes ☐ No

_____

The following information is essential for this office to provide dental care in a manner that is compatible with your general health. Your cooperation in providing accurate information is necessary to meet your dental needs safely and efficiently. Incorrect information can be dangerous to your health.

MEDICAL HISTORY

- *Please write the answer to each question in the space provided.*
- *If the question is not understood, you are not certain of the answer, or you have any questions, indicate so in the space and discuss the matter with the doctor.*
- *All questions must be answered.*

1. Are you currently under the care of a physician? If yes, for what reason or condition? _____

_____

2. Are you currently taking any medications? If yes, what medication and for what reason?_____

_____

3. What vitamin or herbal supplements are you taking?_____

_____

4. Please list dates and reasons for hospitalizations._____

_____

5. Please list allergies to drugs or medications._____

_____

6. Have you ever been treated for the following conditions:

☐ Abnormal blood pressure	☐ Congenital heart disease	☐ Heart trouble	☐ Rheumatic heart disease
☐ AIDS	☐ Convulsions	☐ Hepatitis	☐ Rheumatism
☐ Anemia	☐ Diabetes	☐ Irregular heart beat	☐ Serious head or neck injury
☐ Angina	☐ Excessive bleeding	☐ Jaundice	☐ Stomach or intestinal disease
☐ Arthritis	☐ Fainting spells	☐ Kidney problems	☐ Stroke
☐ Asthma	☐ Hay fever	☐ Liver disease	☐ Tuberculosis
☐ Breathing problems	☐ Heart attack	☐ Pacemaker	☐ Tumors or growths
☐ Cancer	☐ Heart murmur	☐ Renal dialysis	☐ Venereal disease
☐ Chemotherapy	☐ Heart surgery	☐ Rheumatic fever	☐ X-ray treatment

☐ Other: _____

If you checked yes to any of the above conditions please explain: _____

_____

7. Are you on a special diet? If yes, for what reason? _____

_____

8. Do you smoke? If yes, describe type and frequency: _____

_____

9. Have you consulted or been treated by a psychiatrist, psychologist or counselor? If so, for what reason?_____

_____

10. Are there any other health issues that you are aware of? _____

_____

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

_____

DENTAL HISTORY

1. What would you like done for your mouth? _____
2. Are you satisfied with the appearance of your teeth? _____
3. Are you satisfied with your ability to chew? _____
4. Would you like information about the following (check if yes):
   - ☐ Dental Implants
   - ☐ Invisalign
   - ☐ Teeth whitening
   - ☐ Other: _____
5. Do your gums bleed when brushing or eating?_____
6. Does food catch between your teeth?_____
7. Have your teeth shifted, are there spaces between your teeth now where there were none, are your teeth flaring, or are some of you teeth becoming loose? _____
8. Are any of your teeth sensitive to heat, cold, or pressure? _____
9. Do you grind your teeth or clench your jaws? _____
10. Do you have pain or clicking in the jaw joint around your ear?_____
11. Have your jaw muscles ever been sore? If yes, please describe. _____
12. Are there any sores or growths in your mouth? _____
13. Do any of your teeth ache? _____
14. Do you have any other dental complaints? _____

In respect to previous dental treatment have you (check if yes):

☐ Ever fainted

☐ Had an allergic reaction

☐ Had abnormal bleeding

☐ Other complications during or following dental treatment.

Please describe any checked boxes: _____

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: _____