Medical History

Date_____

Patient Information

First Name:_____ Middle Initial:_____ Last Name:_____

Address:_____

Home Phone:_____ Cell Phone:_____

Date of Birth:_____ Social Security #:_____ Sex:_____

Employer:_____ Work Phone:_____

Marital Status: Single Married Separated Divorced Widowed

Emergency Contact:_____ Phone #:_____ Relation:_____

Who do we have the pleasure to thank for referring you to us?_____

Primary Insurance Information

Policy Holder's Name:_____ Relationship to Patient:_____

Address:_____ Phone Number:_____

Date of Birth:_____ Social Security Number/ID Number:_____

Employer:_____ Dental Insurance Company:_____

Mailing Address:_____ Group #:_____

Secondary Insurance Information

Policy Holder's Name:_____ Relationship to Patient:_____

Address:_____ Phone Number:_____

Date of Birth:_____ Social Security Number/ID Number:_____

Employer:_____ Dental Insurance Company:_____

Mailing Address:_____ Group #:_____

Medical Information

Physician's Name:_____ Hospital:_____

City:_____ State:_____ Phone:_____ Date of Last Visit:_____

Are you currently undergoing any medical treatment with a physician? If so, what for?_____

_____

Have you had any surgeries? If so, please list._____

Yes	No	**Please mark an X for the following questions accordingly. Please explain any YES answers in the designated area below.**
		Do you have any Eye, Ear, Nose or Throat problems? (Ex. Cataract, Glaucoma, Hearing Impairment, etc.)
		Do you have any Heart or Blood Pressure problems? (Ex. Artificial Valves, Congenital Heart Disease, etc.)
		Do you have any Breathing or Lung problems? (Ex. Asthma, COPD, Sleep apnea, Pneumonia, etc.)
		Do you have any Stomach, Intestine, or Liver disorders? (Ex. Crohn's, Acid Reflux, Celiac's, IBS, etc.)
		Do you have an Eating disorder? (ex. Bulimia, Anorexia, Purging, etc.)
		Do you have any Kidney or Urinary disorders? (Ex. Renal Failure, Urinary Incontinence, etc.)
		Do you have any Muscle or Bone disorders? (ex. Osteoarthritis, Gout, TMJ, Fibromyalgia, etc.)
		Do you have any skin problems? (Ex. Eczema, Psoriasis, etc.)
		Do you have any Neurologic or Nerve problems? (Ex. Stroke, Seizures, Parkinson's, Alzheimer's, etc.)
		Do you have any Mental Health disorders? (Ex. Depression, PTSD, Bipolar, Anxiety, etc.)
		Do you have any Diabetes or Endocrine disorders? (Ex. Type 1, Type 2, Thyroid Problems, etc.)
		Do you have any Blood or Hematologic disorders? (Ex. Anemia, Leukemia, Sickle Cell, etc.)
		Do you have any Immune System disorders? (Ex. Lupus, Rheumatoid arthritis, etc.)
		Do you have any Infectious diseases? (Ex. Hepatitis A, B/D, or C, STD, HIV/AIDS, cold sores, etc.)
		Do you have any joint replacements? (Ex. Hip, Knee, Shoulder, Elbow, Ankle, etc.)
		Do you use any tobacco products, illicit drugs, or alcohol? If yes, what and how often?
		Do you pre-medicate prior to Dental Treatment for any of the following reasons? Artificial Heart Valve, Previous Infective Endocarditis, Heart Transplant, Congenital Heart Disease

Please explain any YES answers from the previous list of questions:

_____
_____
_____
_____
_____

Yes	No	FEMALES ONLY
		Are you or could you be pregnant? If yes, how many weeks?
		Are you currently nursing?
		Are you taking any birth control, Fertility Drugs or Hormone replacements?

Do you currently take any medications? Prescription, over the counter, dietary supplements, herbal medicine or vitamins? (If you have more than five medications, we would be happy to make a copy of your list for you)

Medications or Supplements	Dose	Frequency	Date Started	Reason for Use

Under no circumstance will we ever advice you to stop taking any of your medications.

Please list any allergies to any medications, metals, latex, or food?_____

Dental Information

Previous Dentist:_____ Date of Last Dental Exam:_____

Address_____ Office Phone:_____

Do you have current x-rays that you would like transferred to our office?___Yes/No_____

How do you feel about your current smile?_____

Yes	No	**Please mark an X for the following questions accordingly.**
		Do you brush your teeth twice daily? If no, how often?
		Do you floss or Waterpik daily? If no, how often?
		Do your gums bleed when you brush and floss?
		Are your teeth sensitive to hot, cold, sweets or pressure?
		Is your mouth dry?
		Have you had any perio (gum) treatments? If yes, When?
		Have you gone through orthodontic (braces) treatment? If yes, When?
		Is your home water supply fluoridated?
		Do you have any earaches or neck pain?
		Do you have any popping, clicking or discomfort in your jaw?
		Do you brux, clench, or grind your teeth?
		Do you have any sores or ulcers in your mouth?
		Do you wear partials or dentures? If yes, when were they last made?

Note: Both Patient and Doctor are encouraged to discuss any and all relevant health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and the staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or the staff responsible for any action they take or do not take because or errors or omissions that I may have made in the completion of this form.

Signature of Patient/Guardian:_____