



Medical & Dental History

Today's Date _____/_____/_____

Name (Last) _____ (First) _____ (MI) _____

Have you had dental x-rays within the last 12 months? _____ If so, please bring copies of the x-rays to your dental appointment. If you choose not to obtain those x-rays, we will need to take a new series of x-rays which consist of a panorex and bitewing x-rays.

What is the reason for your visit today? _____

Have you had hip/knee replacement surgery or any heart surgery within the last two years? _____ **If yes, please let us know so that we may determine whether you may need an antibiotic prior to your appointment.**

Would you consider yourself to be in fairly good health?

Yes No

Within the past year, have there been any changes in your general health?

Yes No

What is the date (or approximate date) of your last medical and dental exam?

Your Primary Care Physician's name, address & phone number? _____

Do you have or have you ever had any of the following?

- | Yes | No | Yes | No |
|--------------------------|--|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> | <input type="checkbox"/> Alcohol/Drug Abuse |
| <input type="checkbox"/> | <input type="checkbox"/> Anemia | <input type="checkbox"/> | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> Artificial bones/joints | <input type="checkbox"/> | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> Blood Disease/Transfusion | <input type="checkbox"/> | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> | <input type="checkbox"/> Colitis | <input type="checkbox"/> | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> Emphysema | <input type="checkbox"/> | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> | <input type="checkbox"/> Fainting | <input type="checkbox"/> | <input type="checkbox"/> Frequent Headaches |
| <input type="checkbox"/> | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> Hayfever/Seasonal Allergies |
| <input type="checkbox"/> | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> | <input type="checkbox"/> Heart Murmur/Mitral Valve Prolapse |
| <input type="checkbox"/> | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> Fever Blister/Herpes |
| <input type="checkbox"/> | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> HIV |
| <input type="checkbox"/> | <input type="checkbox"/> Jaundice | <input type="checkbox"/> | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> | <input type="checkbox"/> Premedication needed | <input type="checkbox"/> | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> | <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> | <input type="checkbox"/> Stroke | <input type="checkbox"/> | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> | <input type="checkbox"/> Tuberculosis/TB | <input type="checkbox"/> | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> | <input type="checkbox"/> Ulcers | <input type="checkbox"/> | <input type="checkbox"/> Venereal Disease/VD |

WOMEN ONLY: Are you pregnant?

Yes No If yes, due date? _____

Are you allergic to any of the following?

- | Yes | No | | Yes | No | |
|--------------------------|--------------------------|-------------|--------------------------|--------------------------|---------|
| <input type="checkbox"/> | <input type="checkbox"/> | Penicillin | <input type="checkbox"/> | <input type="checkbox"/> | Codeine |
| <input type="checkbox"/> | <input type="checkbox"/> | Novocaine | <input type="checkbox"/> | <input type="checkbox"/> | Aspirin |
| <input type="checkbox"/> | <input type="checkbox"/> | Sulfa Drugs | <input type="checkbox"/> | <input type="checkbox"/> | Latex |
| <input type="checkbox"/> | <input type="checkbox"/> | Amoxicillin | <input type="checkbox"/> | <input type="checkbox"/> | Other |

- Yes No Have you ever had complications following dental treatment?
- Yes No Are you currently under the care of a physician due to a specific condition?
- Yes No Have you been hospitalized within the last 5 years due to a surgery or illness?
- Yes No Do you use tobacco products (smoking or chewing)?
- Yes No Do you require the use of corrective lenses (contacts or glasses)?
- Yes No Do you have any conditions, diseases, etc., not listed above?

Please list any medications (prescription and non-prescription) that you are taking?

How frequently do you brush your teeth? 3+/day 2 X per day 1 X/day Weekly

How frequently do you floss your teeth? 1+/day 2-6 weekly 1-6 monthly Never

- Yes No Do your gums bleed when you brush or floss?
- Yes No Do your teeth experience sensitivity to cold or hot temperatures?
- Yes No Are any of your teeth currently causing you pain?
- Yes No Do you grind your teeth (either consciously or during sleep)?
- Yes No Are any of your teeth loose, or are you concerned about any teeth loosening?
- Yes No Do you currently have any dental implants, dentures or partials?
- Yes No Do you snore?
- Yes No Would you like your teeth whiter?

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential to being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare providers. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Patient/Parent or guardian

Doctors Signature
