

# PATIENT'S MEDICAL HISTORY

Name \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex F M  
 Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_ County \_\_\_\_\_  
 Phone (Area Code) \_\_\_\_\_ Work Phone \_\_\_\_\_ Driver's License No. \_\_\_\_\_  
 Cell Phone \_\_\_\_\_ E-mail address \_\_\_\_\_  
 Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Social Security No. \_\_\_\_\_  
 Marital Status \_\_\_\_\_ Spouse's Name \_\_\_\_\_ or (if Dependent) Parent's Names \_\_\_\_\_  
 Employer (of Guarantor) \_\_\_\_\_ Employer (of Spouse) \_\_\_\_\_  
 Whom may we thank for this referral? \_\_\_\_\_  
 Medical Doctor \_\_\_\_\_ Office Phone \_\_\_\_\_ Date of Last Physical \_\_\_\_\_  
 Person to notify in case of emergency (outside home) \_\_\_\_\_ Phone \_\_\_\_\_

- Yes  No Are you taking any prescription or non-prescription medications including vitamins, herbal medications, remedies and/or recreational drugs? If yes, please list \_\_\_\_\_
- Yes  No Do you take birth control medication?
- Yes  No Are you allergic to any medication, local anesthetic, materials or latex gloves?
- Yes  No Do you have diabetes? If so, is it type 1  or type 2 ? When was your last HbA1c done? \_\_\_\_\_ what was the level? \_\_\_\_\_
- Yes  No Do you snore or have sleep apnea?
- Yes  No Have you had any major surgery?
- Yes  No Do you have a history of fainting?
- Yes  No Have you ever had a serious accident involving head injuries?
- Yes  No Have you had any radiation, chemotherapy, or other cancer treatment?
- Yes  No Do you have any artificial joints (knee, hip, etc.)?
- Yes  No Have you ever bled excessively after being cut or injured?
- Yes  No Do you have any reason to suspect you have been in contact with the AIDS virus or have tested HIV positive?
- Yes  No Do you use tobacco products? If so, what \_\_\_\_\_ and how often? \_\_\_\_\_
- Yes  No Do you have well water (private)?
- Yes  No Does your drinking water contain fluoride?
- Yes  No Have you ever been treated for gum disease?
- Yes  No Do you clench or grind your teeth?
- Yes  No Do you suffer from headaches?
- Yes  No Does your jaw click or pop?
- Yes  No Have you experienced any pain or soreness in the muscles of your face or around your face or around your ear?
- Yes  No Do you have any dental implants?
- Yes  No Are you happy with your smile?
- Yes  No Would you like a whiter smile?
- Yes  No Are you interested in straightening your teeth?
- Yes  No Are you concerned with your breath?
- Yes  No Are you interested in sedation dentistry?

### Do You Have Or Have You Ever Had:

- |  |  |
|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Any Heart Condition                               | <input type="checkbox"/> Yes <input type="checkbox"/> No Ulcer or GERD   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No High/Low Blood Pressure                           | <input type="checkbox"/> Yes <input type="checkbox"/> No Cortisone-Steroid Treatment   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Stroke or Mini Stroke                             | <input type="checkbox"/> Yes <input type="checkbox"/> No Breathing Problems  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Pacemaker   | <input type="checkbox"/> Yes <input type="checkbox"/> No Sinus Problems  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Artificial/Prosthetic Heart Valve                 | <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Congenital Heart Disease (heart defects at birth) | <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Transplant                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No Hay Fever   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Bacterial Endocarditis                            | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Trouble  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Anemia, or Excessive Menstrual Bleeding           | <input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Blood Transfusions                                | <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer or Malignancy  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Blood Disease/Leukemia                            | <input type="checkbox"/> Yes <input type="checkbox"/> No Osteoporosis  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Liver Disease, Hepatitis, and/or Jaundice         | <input type="checkbox"/> Yes <input type="checkbox"/> No Sexually Transmitted Disease  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Nervous Disorder                                  | <input type="checkbox"/> Yes <input type="checkbox"/> No Is there any chance that you could be pregnant?<br>If yes, delivery date: _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy  |  |

**Do you have any disease, condition or problem not listed or anything about your health that we have not covered?**  Yes  No

**Explain all YES answers:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Date of Last Dental Visit \_\_\_\_\_ Do you have an immediate dental problem  Yes  No  
 Were x-rays taken at that time  Yes  No If so, where does it bother you \_\_\_\_\_  
 Were your teeth cleaned  Yes  No When did it start \_\_\_\_\_

### RELEASE:

- A. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
- B. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
- C. I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.
- D. I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.
- E. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill of services. I understand I am financially responsible for payments in full for all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.
- F. I attest to the accuracy of the information on this page. I understand that it is my responsibility to inform the Dr. and the office staff of any changes in my medical status at the very next appointment, before any further treatment is rendered to me.

\_\_\_\_\_  
 PATIENT'S or GUARDIAN'S SIGNATURE                      Relationship to Patient                      Date                      Doctor's Signature Upon Completion