



Medical History

Name _____

DOB _____

- 1 Yes No Driver's license #: _____
- 2 Yes No Married? If yes, spouse's name: _____
- 3 Yes No Are you taking any prescription or non-prescription medications including vitamins, herbal medications, remedies and/or recreational drugs? If so, please list _____
- 4 Yes No Do you take birth control medication?
- 5 Yes No Are you allergic to any medication, local anesthetic, materials or latex gloves?
- 6 Yes No Do you have diabetes? If so, type 1 or type 2
- 7 Yes No If yes to question 6, when was your last HbA1c done and what was the level? _____
- 8 Yes No Do you snore or have sleep apnea?
- 9 Yes No Have you had any major surgery?
- 10 Yes No Do you have a history of fainting?
- 11 Yes No Have you ever had a serious accident involving head injuries?
- 12 Yes No Have you had any radiation, chemotherapy or other cancer treatment?
- 13 Yes No Do you have any artificial joints (knee, hip, etc) ?
- 14 Yes No Have you ever bled excessively after being cut or injured?
- 15 Yes No Do you have any reason to suspect you have been in contact with the AIDS virus or have tested positive for HIV?
- 16 Yes No Do you use tobacco products? If so, what and how often? _____
- 17 Yes No Do you have well water (private)?
- 18 Yes No Does your drinking water contain fluoride?
- 19 Yes No Have you ever been treated for gum disease?
- 20 Yes No Do you clench or grind your teeth?
- 21 Yes No Do you suffer from headaches?
- 22 Yes No Does your jaw click or pop?
- 23 Yes No Have you experienced any pain or soreness in the muscles of your face or around your face or around your ear?
- 24 Yes No Do you have any dental implants?
- 25 Yes No Are you happy with your smile?
- 26 Yes No Would you like a whiter smile?
- 27 Yes No Are you interested in straightening your teeth?
- 28 Yes No Are you concerned with your breath?
- 29 Yes No Are you interested in sedation dentistry?

Do you have or have you ever had:

- 30 Yes No Any heart condition
- 31 Yes No High/Low Blood Pressure
- 32 Yes No Stroke or Mini Stroke
- 33 Yes No Pacemaker
- 34 Yes No Artificial/prosthetic heart valve
- 35 Yes No Congenital heart disease (heart defects at birth)
- 36 Yes No Heart transplant
- 37 Yes No Bacterial Endocarditis
- 38 Yes No Anemia or excessive menstrual bleeding
- 39 Yes No Blood transfusion
- 40 Yes No Blood disease/Leukemia
- 41 Yes No Liver disease, hepatitis and or jaundice
- 42 Yes No Nervous disorder
- 43 Yes No Epilepsy
- 44 Yes No Ulcer or GERD
- 45 Yes No Cortisone-Steroid treatment
- 46 Yes No Breathing problems
- 47 Yes No Sinus problems
- 48 Yes No Asthma
- 49 Yes No Tuberculosis
- 50 Yes No Hay fever
- 51 Yes No Kidney trouble
- 52 Yes No Arthritis
- 53 Yes No Cancer or malignancy
- 54 Yes No Osteoporosis
- 55 Yes No Sexually transmitted disease
- 56 Yes No Is there a chance that you could be pregnant? If yes, delivery date.
- 57 Yes No Do you have any disease, condition or problem not listed or anything about your health that we have not covered? If so, please list: _____

Please explain any YES answers:

58

Date of your last dental visit. _____

59 Yes No

Were x-rays taken at that time?

60 Yes No

Were your teeth cleaned?

61 Yes No

Do you have an immediate dental problem? If so, where does it bother you and when did it start?

62 Medical doctor name & phone #:

63 Date of last physical: _____

64 In case of an emergency, person outside of the home to contact & phone #:

RELEASE:

- A. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
- B. I authorize the 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 the 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 of this page. I understand that it is my responsibility to inform the Doctor 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

Medical History Update

I have accurately advised my dental care provider of my *current* health status and any dietary or herbal supplements, medications and/or drugs (including recreational and OTC) that I am taking or have taken in the last week.

SINCE YOUR LAST VISIT: Has there been any change in your health status? ___Yes ___No Hospitalized? ___Yes ___No
 Changes/Updates: _____
 Present medications: _____

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SINCE YOUR LAST VISIT: Has there been any change in your health status? ___Yes ___No Hospitalized? ___Yes ___No
 Changes/Updates: _____
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