

# MEDICAL/DENTAL HISTORY FORM

Today's Date: \_\_\_\_\_ Who may we thank for referring you? \_\_\_\_\_

Patient Name: \_\_\_\_\_  
Last First MI

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Marital Status: \_\_\_\_\_ SS#: \_\_\_\_\_

Billing Address: \_\_\_\_\_

City State Zip Code

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Employer: \_\_\_\_\_

**ACCOUNT INFORMATION:** Person Responsible for account  Check if same as above

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Billing Address: \_\_\_\_\_

City State Zip Code

## INSURANCE INFORMATION:

**Primary Dental Insurance:** \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_  
City State Zip Code

Subscriber ID: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_

**Secondary Dental Insurance:** \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_  
City State Zip Code

Subscriber ID: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_

**Medical Insurance:** \_\_\_\_\_

Address: \_\_\_\_\_ Phone #: \_\_\_\_\_  
City State Zip Code

Subscriber ID: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Subscriber's Employer: \_\_\_\_\_

- Continue to Other Side -

# MEDICAL/DENTAL HISTORY FORM (CONTINUED FROM FRONT)

Patient's Name \_\_\_\_\_  
Last First Middle

**What is your reason for seeking dental treatment?**  Checkup for all necessary dental care  Dental care for a specific problem

Explain \_\_\_\_\_

Name of Physician \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Name of Previous Dentist \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Were Oral X-Rays taken? \_\_\_\_\_ Yes \_\_\_\_\_ No How Long Ago? \_\_\_\_\_

### Please Answer All Questions

1. Are you under a physician's care now?  Yes  No
2. Have you been hospitalized or had a serious illness within the past 5 years?  Yes  No
3. Date of last medical examination: \_\_\_\_\_
4. Are you pregnant? \_\_\_\_\_ How many weeks? \_\_\_\_\_
5. Have you had any complications with past pregnancies?  Yes  No
6. Are you taking any medications or drugs at present?  Yes  No  
If so, please list them in space at bottom of page.

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

7. Heart disease  Yes  No
8. Shortness of breath with limited activity or when resting  Yes  No
9. Chest pain or angina pectoris  Yes  No
10. Heart attack  Yes  No
11. Mitral valve prolapse  Yes  No
12. Rheumatic fever or rheumatic heart disease  Yes  No
13. Heart murmur  Yes  No
14. Heart defect from birth  Yes  No
15. High blood pressure  Yes  No
16. Stroke  Yes  No
17. Fainting spells, convulsions or epilepsy  Yes  No
18. Nervous breakdown or emotional problems  Yes  No
19. Lung disease (T.B., asthma, emphysema or other)  Yes  No
20. Liver disease (jaundice, cirrhosis or other)  Yes  No
21. Hepatitis (A, B, C)  Yes  No
22. Kidney disease  Yes  No
23. Diabetes  Yes  No
24. Prolonged bleeding following injuries or surgery  Yes  No
25. Blood disorder  Yes  No
26. Venereal disease (syphilis, gonorrhea); Herpes  Yes  No
27. A.I.D.S./HIV  Yes  No
28. Arthritis  Yes  No
29. X-ray treatments or radiation therapy  Yes  No
30. Treatment for a tumor or growth  Yes  No
31. Do you have any limitations regarding activity or diet?  Yes  No  
If so, what? \_\_\_\_\_
32. Have you had joint surgery or a prosthetic joint replacement? \_\_\_\_\_  Yes  No
33. Headaches, neckaches, backaches?  Yes  No

- Have you become sick from, shown any allergy to, or been told not to take the following:
34. Penicillin/Amoxicillin, Tetracycline, or other antibiotics  Yes  No
  35. Aspirin, codeine or other pain medications  Yes  No
  36. Novocaine, xylocaine, or other anesthetics  Yes  No
  37. Other medications \_\_\_\_\_  Yes  No
  38. Latex  Yes  No
  39. Is there anything of importance in your medical history that has not been asked?  Yes  No  
Explain \_\_\_\_\_

40. Do you have problems with any of the following?  
Check those that apply.  
 Pain in teeth or gums  Sensitivity to hot/cold/sweet  
 Pain or noise in jaw joint  Pain in head/neck  
 Pain in jaws  Swelling  
 Sores on lips/on mouth  Loose teeth  
 Food sticking between teeth  Bad breath  
 Bleeding gums when flossing  
 Bleeding gums when brushing  Dentures/bridges
41. Have you ever had:  
Tooth extraction? \_\_\_\_\_ Oral Surgery? \_\_\_\_\_ Any difficulty? \_\_\_\_\_  
Periodontal (gum) surgery? \_\_\_\_\_ Injury to jaws/teeth? \_\_\_\_\_
42. Have you ever had problems in connection with the above?  
Excessive or prolonged bleeding \_\_\_\_\_ Delayed healing \_\_\_\_\_
43. Have you ever had Conscious Sedation, IV or Oral?  Yes  No
44. Have you ever had:  
Removable dentures/bridges/appliances? \_\_\_\_\_  
Spare denture(s) \_\_\_\_\_  
Soreness/looseness with your denture(s)? \_\_\_\_\_
45. Have you ever had an unusual reaction to any dental treatment?  Yes  No  
Explain \_\_\_\_\_

Medications Currently Being Used include prescription and non-prescription drugs, herbal medicines, diet pills, potency medications, Bisphosphonates (Reclast, Boniva) etc.:

Medical History Updates (include recent hospitalizations): \_\_\_\_\_

Our policy requires payment in full for all services rendered at the time of visit. If account is not paid within 90 days of the date of service you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I hereby authorize assignment of my insurance rights and health benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

Patient or Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_