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 –

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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 _____
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
    - ☐ Pain or noise in jaw joint
    - ☐ Pain in jaws
    - ☐ Sores on lips/on mouth
    - ☐ Food sticking between teeth
    - ☐ Bleeding gums when flossing
    - ☐ Bleeding gums when brushing
    - ☐ Sensitivity to hot/cold/sweet
    - ☐ Pain in head/neck
    - ☐ Swelling
    - ☐ Loose teeth
    - ☐ Bad breath
    - ☐ 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**

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