

Patient Medical History

Patient Name _____ Date of Birth _____

Physician _____ Physician Phone Number _____

- | | YES | NO |
|--|-----|-----|
| 1. Are you under medical treatment now?
If yes, please explain _____ | ___ | ___ |
| 2. Have you been hospitalized for any surgical operation or serious illness within the last 5 years?
If yes, please explain _____ | ___ | ___ |
| 3. Are you taking any medication(s) including non-prescription medicine?

If yes, please list _____ | ___ | ___ |

- | | | |
|---|-----|-----|
| 4. Do you use tobacco? | ___ | ___ |
| 5. Do you use controlled substances? | ___ | ___ |
| 6. Are you wearing contact lenses? | ___ | ___ |
| 7. Please check any of the following that apply to you: | | |

- | | | |
|--|--|---|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Easily Winded |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Cardiac Pacemaker | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Hay Fever/Allergies |
| <input type="checkbox"/> Swollen Ankles | <input type="checkbox"/> Angina | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Fainting/Seizures | <input type="checkbox"/> Frequently Tired | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Anemia | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Recent Weight Loss |
| <input type="checkbox"/> Epilepsy/Convulsions | <input type="checkbox"/> Cancer | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Trouble |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Joint Replacement/Implant | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Kidney Diseases | <input type="checkbox"/> Hepatitis/Jaundice | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> AIDS or HIV Infection | <input type="checkbox"/> Stomach Troubles/Ulcers | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Thyroid Problem | <input type="checkbox"/> Chest Pains | |

8. Are you allergic to or have you had any reactions to the following:
- | | |
|--|--|
| <input type="checkbox"/> Local Anesthetics (e.g. Novocain) | <input type="checkbox"/> Iodine |
| <input type="checkbox"/> Penicillin or any other Antibiotics | <input type="checkbox"/> Aspirin |
| <input type="checkbox"/> Sulfa Drugs | <input type="checkbox"/> Any Metals (e.g. nickel, mercury, etc.) |
| <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Latex Rubber |
| <input type="checkbox"/> Sedatives | <input type="checkbox"/> Other _____ |

- | | YES | NO |
|---|-----|-----|
| 9. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? | ___ | ___ |
| 10. (Women Only) Are you pregnant or think you may be pregnant? | ___ | ___ |
| Are you nursing? | ___ | ___ |
| Are you taking oral contraceptives? | ___ | ___ |

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN

DATE

Date _____

Patient Information

First Name _____ Middle Initial _____ Last Name _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Birthdate _____ Social Security # _____ Male _____ Female _____

Check Appropriate: ___Minor ___Single ___Married ___Separated ___Divorced ___Widowed

Spouse's Name _____ If Student, Name of School/College _____

Patient's Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

(if other than patient listed above)

Name of Person Responsible for Account _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Birthdate _____ Social Security # _____ Is this Person Currently a Patient in our Office? _____

Employer _____ Work Phone _____

For your convenience, we offer the following methods of payment. Please check the option you prefer.

Payment in full is expected at each appointment.

___Cash/Check ___Visa/MC/Discover ___I wish to discuss the office's payment policy

Patient Dental History

Name of Previous Dentist _____ Approx. Date of Last Exam/Cleaning _____

YES NO

- 1. Do your gums bleed while brushing or flossing? _____
- 2. Are your teeth sensitive to hot or cold liquids/foods? _____
- 3. Are your teeth sensitive to sweet or sour liquids/foods? _____
- 4. Do you feel pain to any of your teeth? _____
- 5. Do you have any sores or lumps in or near your mouth? _____
- 6. Have you had any head, neck, or jaw injuries? _____
- 7. Have you ever experienced any of the following problems in your jaw?
 - Clicking _____
 - Pain (joint, ear, side of face) _____
 - Difficulty in opening or closing _____
 - Difficulty in chewing _____
- 8. Do you have frequent headaches? _____
- 9. Do you clench or grind your teeth? _____
- 10. Do you bite your lips or cheeks frequently? _____
- 11. Have you ever had any difficult extractions in the past? _____
- 12. Have you ever had any prolonged bleeding following extractions? _____
- 13. Have you had any orthodontic treatment? _____
- 14. Do you wear dentures or partials? _____
 - If yes, date of placement _____
- 15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? _____
- 16. Do you like your smile? _____