PATIENT MEDICAL HISTORY

Patient's Name _____ Date of Birth _____

Responsible Party _____ Phone _____ SSN _____ TDL _____

Address _____ City _____ State _____ ZIP _____

Emergency Contact _____ Emergency Phone _____

	Y	N
1. Are you in good health	☐	☐
2. Have there been any changes in your general health within the past year	☐	☐
3. Date of your last physical exam _____		
4. Are you under the care of a physician	☐	☐
5. Physician's Name _____ Address _____ Phone _____		
6. Have you ever been hospitalized for any surgical operation or serious illness Please explain: _____	☐	☐
7. Are you taking any medicines(s), including non-prescription medicine Please explain: _____	☐	☐
8. Have you had any abnormal bleeding	☐	☐
9. Do you bruise easily	☐	☐
10. Have there been any changes in your general health within the past year	☐	☐
11. Are you in good health	☐	☐
12. Have you ever taken Fen-Phen/Redux	☐	☐
13. Do you use tobacco	☐	☐
14. Do you or have you used controlled substances	☐	☐
15. Are you wearing contact lenses	☐	☐
16. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than three weeks)	☐	☐
17. Do you have any disease, condition or problem not listed about that you think we should know about	☐	☐

Women Only:

Are you pregnant, or think you may be	☐	☐
Are you nursing	☐	☐
Are you taking birth control pills	☐	☐

Please list any known allergies:

_____

Do you have, or have you ever had the following:

	Y	N
Rheumatic Heart Disease or Rheumatic Fever	☐	☐
Scarlet Fever	☐	☐
Heart Defect or Heart Mumur	☐	☐
Heart Trouble, Heart Attack or Angina	☐	☐
Chest Pain	☐	☐
Shortness of Breath	☐	☐
Pacemaker	☐	☐
Heart Surgery	☐	☐
High Blood Pressure	☐	☐
Low Blood Pressure	☐	☐
Swelling of Feet, Ankles or Hands	☐	☐
Hepatitis, Jaundice or Liver Disease	☐	☐
Stroke	☐	☐
Sinus Trouble	☐	☐
Lung or Breathing Problems	☐	☐
Asthma or Hay Fever	☐	☐
Hives or Skin Rash	☐	☐
Fainting or Dizzy Spells	☐	☐
Diabetes	☐	☐
AIDS or HIV Infection	☐	☐
Thyroid Problems	☐	☐
Allergies	☐	☐
Arthritis or Rheumatism	☐	☐
Joint Replacement or Implant	☐	☐
Stomach Ulcer	☐	☐
Kidney Trouble	☐	☐
Tuberculosis	☐	☐
Cough that produces blood	☐	☐
Chemotherapy (Cancer, Leukemia)	☐	☐
Sexually Transmitted Disease	☐	☐
Epilepsy or Seizures	☐	☐
Anemia	☐	☐
Glaucoma	☐	☐
Tumors	☐	☐
Back Problems	☐	☐
Chemical Dependency	☐	☐
Mirtal Valve Prolapse	☐	☐
Cortisone Treatment	☐	☐
Cold Sore / Fever Blisters	☐	☐
Hypoglycemia	☐	☐
Eating Disorders	☐	☐

HEALTH HISTORY

PATIENT MEDICAL HISTORY

Patient's Name _____ Date of Birth _____

	Y	N
Do your gums bleed while brushing or flossing	☐	☐
Are your teeth sensitive to hot or cold liquids/foods	☐	☐
Are your teeth sensitive to sweet or sour liquids/foods	☐	☐
Do you feel pain in any of your teeth	☐	☐
Do you have any sores or lumps in or near your mouth	☐	☐
Have you had any head, neck or jaw injuries	☐	☐
Following problems in your jaw?		
Clicking	☐	☐
Pain (Joint, Ear, Side of Face)	☐	☐
Difficulty in Opening or Closing	☐	☐
Difficulty in Chewing	☐	☐
Do you have frequent headaches	☐	☐
Do you clench or grind your teeth	☐	☐

	Y	N
Do you bite your lips or cheeks frequently	☐	☐
Have you noticed and loosening of your teeth	☐	☐
Does food tend to get caught between your teeth	☐	☐
Have you ever had periodontal treatment (gums)	☐	☐
Ever worn a bite plate or other applicance	☐	☐
Have you ever had any difficult extractions in the past	☐	☐
Have you ever had any prolonged bleeding following extractions	☐	☐
Do you wear dentures or partials	☐	☐
If yes, date of placement _____		
Have you ever received oral hygiene instructions regarding the care of your teeth and gums	☐	☐

If you could change ANYTHING about your smile, what would you change?

_____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to the third party payors and/or health practitioners I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pass less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____

Signed By Date

Doctor's Comments _____

_____

_____ Signature _____ Date _____

Print Form