PATIENT MEDICAL HISTORY

Patient's Name:

,

For Office Use Only
ID: 43603

Address:	Today's Date:	Date of Last Visit:	Date of Med. History:
	10/28/2018	02/11/1991	10/28/2018

City State Zip:	Email:
,	

Home Phone:	Work Phone:	Cell Phone:	Birth Date:	Social Security No.:	Marital Status:
					Unknown

Primary Dental Guarantor:	Home Phone:	Work Phone:	Cell Phone:

Secondary Dental Guarantor:	Home Phone:	Work Phone:	Cell Phone:

Physician Name:	Physician Phone:

Pharmacy:	Pharmacy Phone:

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Medical Alerts:

Sex: Unknown

If female please answer the following:

Y	N	
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are you pregnant? If Yes, # of weeks ☐
☐	☐	Are you nursing?

Please answer the following:

Y	N	
☐	☐	Do you smoke or use tobacco?

For Office Use Only
BP / Heart Rate:

Height:

Weight:

Y	N	Conditions
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Heart Valve
☐	☐	Artificial Joint
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Chemotherapy
☐	☐	Congenital Heart Lesion
☐	☐	Cortisone Medicine
☐	☐	Dental Implants
☐	☐	Diabetes
☐	☐	Drug Addictions
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Excessive Bleeding
☐	☐	HIV+ AIDS
☐	☐	Heart Attack
☐	☐	Heart Murmur
☐	☐	Heart Surgery
☐	☐	Hemophilia

Y	N	Conditions
☐	☐	Hepatitis (Infectious)
☐	☐	Hepatitis B
☐	☐	High Blood Pressure
☐	☐	Kidney Problems
☐	☐	Leukemia
☐	☐	Liver Disease
☐	☐	Nervous Problems
☐	☐	Pace Maker
☐	☐	Pre-Med
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy (Head And Neck
☐	☐	Rheumatic Fever
☐	☐	Sinus Problems
☐	☐	Special Diet
☐	☐	Stroke
☐	☐	Thyroid Conditions
☐	☐	Tuberculosis
☐	☐	Ulcers
☐	☐	Venereal Disease
☐	☐	X-Ray Or Cobalt Treatments
☐	☐	
☐	☐	

Y	N	Conditions
☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

_____

_____

_____

Medications:

Y N

☐ ☐ **Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below...**

Notes:

DENTAL HISTORY:
Last Dental Visit: Previous Dentist:
Do you floss?: Yes or No How often:
Do your gums bleed while brushing or flossing? Yes/No
Are your teeth sensitive to: Hot:____ Cold:_____Sweets:____
Do you feel pain in any of your teeth? Yes/No
Do you have any sores or lumps in or near your mouth? Yes/No
Have you had any head, neck or jaw injuries? Yes/No
Have you experienced any of the following problems in your jaw?
Clicking: Yes /No Pain (joint, ear, side of face): Yes/No
Difficulty in opening or closing: Yes/No Difficulty in chewing: Yes/No
Frequent headaches: Yes/No Clinching and Grinding: Yes/No
Haveyou had any orthodontic treatment? Yes/No
Do you wear dentures or partials? Yes/No
Do you like your smile? Yes/No
If, no what would you like to change:_____

How or from who did you here about us?_____

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 during the period such dental care to third party payors and/or healthcare 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 pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf. I further agree that if I fail to promptly pay such amounts when due, I will be responsible for all resulting costs, expenses, legal fees.

Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)