



DENTAL HISTORY

Date _____

Name _____
Last First MI MR MRS MS DR

**Welcome! So that we may provide you with the best possible care please complete both sides of the Dental/Medical history form.
 All information is completely confidential.**

What is the reason for your visit today? _____

Do you have any dental problems now? Yes No

Date of last Dental Visit _____ Last Dental Cleaning _____ Last Full mouth x-rays _____

What was done at your last dental visit? _____

Did any previous dentist recommend dental treatment that was never performed? Yes No

If yes, what type of work was it? _____

Why was this treatment never performed? _____

Male ___ Female ___ SS#: _____

Date of Birth: ___/___/_____ Age: _____

Home Address: _____

CITY STATE ZIP

___Single ___Married ___Divorced ___Widowed ___Separated

Hm# (___) _____ Cell# (___) _____

Wk# (___) _____ Ext: _____ DL# _____

Email Address _____

Employer: _____

Employer's Address: _____

Occupation: _____

Where & When are the best time to reach you? _____

Whom may we Thank for referring you? _____

Previous/ Present Dentist: _____

Last Visit Date _____

Spouse Information

Name of Spouse: _____

Employer: _____

Wk# (___) _____ SS# _____

Birth date: ___/___/_____ Cell# _____

Person Responsible for Account:

Hm#: (___) _____ Cell# _____

Billing Address: _____

Relation: _____ SS# _____

Employer: _____

DL# _____

Primary Dental Insurance

Insurance Co. Name _____

Insurance Address: _____

Insurance Phone # (_____) _____

Group# _____ Policy# _____

Insured's Name: _____

Relation: _____ Insured's ID# _____

Date of Birth: ___/___/_____

Insured's Employer: _____

Employer's Address: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Address: _____

Insurance Phone# (_____) _____

Group # _____ Policy # _____

Insured's Name: _____

Relation: _____ Insured's ID# _____

Date of Birth: ___/___/_____

Insured's Employer _____

Employer's Address _____

Person to notify in case of emergency:

His /Her Name _____

Relation: _____

Wk#(___) _____ Hm#(___) _____

Are you allergic to any of the following?

| | | | | | |
|--------------|---|---|--------------------|---|---|
| Aspirin | Y | N | Erythromycin | Y | N |
| Codeine | Y | N | Jewelry / Metals | Y | N |
| Penicillin | Y | N | Dental Anesthetics | Y | N |
| Tetracycline | Y | N | Latex | Y | N |
| Other | Y | N | | | |

Please list any other drugs / materials that you are allergic to: _____

MEDICAL HISTORY

| Patient Name | Health Alert | BP: | |
|--------------|--------------|-----|--|
|--------------|--------------|-----|--|

1. Have you been under the care of a medical doctor during the past 2 years? Yes No

If yes, for what? _____

Physician's Name _____ Phone _____

2. Have you taken any medication / drugs during the past two years? Yes No

3. Are you taking any medication, drugs, or pills now? Yes No

If yes, please list name and dosage _____

4. Have you been a patient in the hospital during the past 5 years? Yes No

5. Do you require antibiotics before dental treatment Yes No

6. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each of them.

| | | | | | | | | |
|-----------------|-----|----|----------------------|-----|----|-----------------------------------|-----|----|
| Tuberculosis | Yes | No | Cortisone Medicine | Yes | No | High / Low Blood Pressure | Yes | No |
| Asthma | Yes | No | Swollen Ankles | Yes | No | HIV+ / AIDS | Yes | No |
| Hay Fever | Yes | No | Venereal Disease | Yes | No | Rheumatic / Scarlet Fever | Yes | No |
| Stroke | Yes | No | Allergies / Hives | Yes | No | Anemia / Radiation Treatment | Yes | No |
| Arthritis | Yes | No | Blood Transfusion | Yes | No | Cancer / Chemotherapy | Yes | No |
| Diabetes | Yes | No | Difficulty Breathing | Yes | No | Congenital Heart Defect | Yes | No |
| Heart Murmur | Yes | No | Drug / Alcohol Abuse | Yes | No | Epilepsy or Seizures | Yes | No |
| Shingles | Yes | No | Sickle Cell Disease | Yes | No | Severe Frequent Headaches | Yes | No |
| Sinus Problems | Yes | No | Heart Attack/ Stroke | Yes | No | Heart Surgery / Pacemaker | Yes | No |
| Ulcer / Colitis | Yes | No | Psychiatric Problem | Yes | No | Mitral Valve Prolapsed | Yes | No |
| Hepatitis | Yes | No | Kidney Problems | Yes | No | Hemophilia/Abnormal Bleeding | Yes | No |
| Glaucoma | Yes | No | Nervous/Anxious | Yes | No | Anemia/Radiation Treatment | Yes | No |
| Liver Disease | Yes | No | Thyroid Problems | Yes | No | Artificial Joints / Hip / Knee | Yes | No |
| Emphysema | Yes | No | Bruise Easily | Yes | No | Artificial Bones /Joints / Valves | Yes | No |

7. Do you have or have you had any disease condition, or problem not listed above? Yes No

If yes, please list: _____

8. **Women** Are you: Pregnant? Yes, _____ Months No **Nursing** Yes No

Taking birth control pills? Yes No

9. Do you smoke or use tobacco in any form? Yes No

10. Have you ever taken Fosamax, or any other bisphosphonate? Yes No

I understand the above information is necessary to provide me with dental care in a safe & efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Patient Signature _____ Date _____

OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein.

Doctor's Signature _____ Date _____

Doctor's Comments: _____

Medical History Update

1. Date: _____ Comments: _____ Signature _____

2. Date: _____ Comments: _____ Signature _____

3. Date: _____ Comments: _____ Signature _____