

Medical History Information

Patient Name:
Last First MI Preferred Name

How would you describe your current MEDICAL health status?

Excellent!! Good Fair Poor Don't Know

What is the date (or approximate date) of your last MEDICAL exam or physical?

Your Primary Care Physician's name, address, & phone number:

Please list all prescription and non-prescription medications, vitamins or supplements you are taking.

Medical Allergies/Reactions

Please indicate if you are allergic to or have reactions to any of the following:

Aspirin/Ibuprofen Tylenol/acetaminphen Penicillin/Amoxicillin Sulfa
 Codeine Latex Local Anesthetic Other: _____

Please mark any of the following to indicate YES in response to the question:

- Within the past year, have there been any changes in your general health?
- Are you currently under the care of a physician due to a specific condition?
- Have you been hospitalized within the last 5 years due to a surgery or illness?
- Have you had any hip, knee or other joint replacements? DATE: _____
- Have you had a cardiac (heart) surgeries or issues?
- Have you ever been told you needed to pre-medicate with antibiotics before dental treatment?
- Have you ever or are you currently using any tobacco products?
- WOMEN ONLY: Are you pregnant? If Yes, when is the due date? _____
- Have you ever taken Actonel, Aredia, Boniva, Didronel, Fosamax, , Reclast, Skelid, or Zometa ?

If any of the previous questions are marked, please explain in detail:

Please mark any of the following medical conditons that apply to you

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> *MVP | <input type="checkbox"/> *Pre Med | <input type="checkbox"/> Allergies | <input type="checkbox"/> Alzeheimer's |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Aspirin Therapy |
| <input type="checkbox"/> Aspirin/ Ibu Allergy | <input type="checkbox"/> Asthma | <input type="checkbox"/> Auto Immune Disease | <input type="checkbox"/> Blood Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Cong Heart Failure | <input type="checkbox"/> Coumadin Therapy | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Fainting | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Gastric Reflux (GERD) | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Graves Disease | <input type="checkbox"/> Hay Fever |
| <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> HIV | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Irritable Bowel Synd | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Latex Allergy/sensit | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Osteopenia/porosis | <input type="checkbox"/> Other |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Penicillin Allergy | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Reynaud's Syndrome | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Smoker | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tumors | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Von Willebrands Synd |

Do you have any other health or medical issues or conditions not listed above?

To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

Signature: _____

Date:

Dental History Information

Patient Name:
Last First MI Preferred Name

How would you describe your current DENTAL health status?

Excellent!! Good Fair Poor HELP!!

What is the reason for your dental visit today?

When was your last visit to the dentist (if to a different office)?

What was done on your last dental visit (if to a different office)?

Prior Dentist's name, address, & phone number:

How frequently do you brush your teeth?

3 (+) a day Twice a day Once a day Weekly Seldom

How frequently do you floss your teeth?

1 (+) a day 2 - 6 weekly 1 - 6 monthly Seldom Never

Please mark any of the following to indicate Yes in response to the question:

- Do your gums bleed when you brush or floss?
 Do your teeth experience sensitivity to cold or hot temperatures?
 Are any of your teeth currently causing you pain?
 Do you grind or clench your teeth (either consciously or during sleep)?
 Are any of your teeth loose, or are you concerned about any teeth loosening?

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- Do you currently have any dental implants, dentures, or partials?
- Do you frequently get mouth ulcers, cold sores or sore spots?
- Have you ever been in orthodontic treatment (braces, Invisalign, appliances, etc)?
- Have you ever had complications following dental treatment?
- Would you like to discuss cosmetic dentistry options (teeth brightening, veneers, etc.) ?

If any of the previous questions are marked, please explain:

If you could change anything about your mouth, teeth, or smile, what would it be?

COMMENTS: Any other information you would like to share ?

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Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian:

Signature: _____

Date:

Relationship to Patient:

Response Date: