Welcome

Patient Medical and Dental History

To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential) Referred by ____________________

Name ____ Date ____________________

Soc. Sec# ________________ Birthday __________ Home Phone __________ Cell Phone __________

Address ______________________________ City ______________ State ______ Zip __________

Check Appropriate Box ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Patient's Employer ____________________________________ Work Phone ____________________

Spouse's Name ______________ Employer ________________ Work Phone ____________________

Person to contact in case of emergency ____

Insurance Information

Name of insured ______________ Relationship to patient ______________ Guarantor Birthday __________

Insurance Co. ________________ Group # ______________ Guarantor S.S.# ________________

Medical Information

1) Physician ______________ Office phone ______________ Date of Last Exam ______________

2) Are you under medical treatment now? ____________________________________

If yes, please explain ____

3) Are you taking any medications, prescriptions or non-prescriptions? ____________________

If yes, please explain ____

4) Are you allergic to or have had any reaction to any medication or substance? ______________

5) Do you smoke or use smokeless tobacco? ____________________________________

6) Women: Are you Pregnant? Yes, ________ months ☐ No

Nursing? ☐ Yes ☐ No

7) Do you have or have you had any disease, conditions, or problems not listed?

If yes, please explain ____

8) Do you have or have you had any of the following? Please check the "Yes" or "No" box.

	Yes	No		Yes	No		Yes	No
Heart (surgery, disease, attack)	☐	☐	Respiratory Problems	☐	☐	Cancer	☐	☐
Chest Pain	☐	☐	Emphysema	☐	☐	Tumors	☐	☐
High Blood Pressure	☐	☐	Asthma	☐	☐	Radiation Therapy	☐	☐
Mitral Valve Prolapse	☐	☐	Liver Disease	☐	☐	Chemotherapy	☐	☐
Heart Murmur	☐	☐	Hepatitis / Jaundice	☐	☐	Frequent Headaches	☐	☐
Stroke	☐	☐	Thyroid Problems	☐	☐	Neurological Disorders	☐	☐
Arthritis / Rheumatism	☐	☐	Kidney Trouble	☐	☐	Epilepsy or Seizures	☐	☐
Artificial Joints (hip, knee, etc.)	☐	☐	Diabetes	☐	☐	Fainting or Dizzy Spells	☐	☐
Sinus Trouble / Allergies	☐	☐	Diet (special / restricted)	☐	☐	Nervous / Anxious	☐	☐
Latex Sensitivity	☐	☐	AIDS or HIV Infection	☐	☐	Psychiatric/Psychological Care	☐	☐

Dental Information

1.) Whom may we thank for referring you?______________________________

2.) What is the reason for your visit today?______________________________
____

3.) What are your present dental problems?______________________________
____

4.) Date of last dental visit______________ Last dental cleaning______________ Last dental X-ray______________

5) Do you have any sores or lumps in or near your mouth?______________________________
If yes, please explain______________________________

6.) Have you had any head, neck or jaw injuries?______________________________
If yes, please explain______________________________

	Yes	No
7.) Do you clench or grind your teeth?	☐	☐
8.) Do you bite your lips or cheeks frequently?	☐	☐
9.) Have you ever experienced any of the following problems in your jaw?		
• Clicking or Popping	☐	☐
• Difficulty in opening or closing	☐	☐
• Pain (joint, ears, or side of face)	☐	☐
10.) Do your gums bleed while brushing or flossing?	☐	☐
11.) Are your teeth sensitive to hot or cold liquids or foods?	☐	☐
12.) Are your teeth sensitive to sweet or sour liquids or foods?	☐	☐
13.) Do you have any pain in any teeth?	☐	☐
14.) Have you noticed any mouth odors or bad tastes?	☐	☐
15.) Have you noticed any loose teeth or changes in your bite?	☐	☐
16.) Have you ever had oral surgery?	☐	☐
17.) Have you ever had periodontal treatment?	☐	☐
18.) Are you satisfied with your teeth's appearance?	☐	☐
19.) Do you feel nervous about having dental treatment?	☐	☐

If yes, what is your biggest concern? ______________________________
____

I understand the above information is necessary to provide dental care in a safe and 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 receptive 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.

Patient/ Guardian Signature ______________________________ Date ______________