HEAVENLY DENTAL ASSOCIATES

Medical/ Dental History Form for Adult Patients

Date of Exam:_____/_____/_____

Name: _____
Last First Mi Mr Mrs Ms Dr

I prefer to be called:_____ _____Male _____Female Birthdate_____/_____/_____

Age:_____ SS#:_____-_____-_____ __Single __Married__Widowed __Divorced __Separated

Address:_____
Street City Zip

Home Phone: (____)_____ Cell #: (____)_____Work Phone: (____)_____ Ext: _____

Email Address: _____@_____

Employer: _____ How long there? _____ Occupation: _____

Employer's Address: _____
City State Zip

Where and when are best times to reach you (Please **CIRCLE**) Morning Mid Day Afternoon Evening

Whom may we thank for referring you to our office? (Please check/list all that apply)

☐**Website** ☐**School Program** ☐**Commercial** ☐**Facebook** ☐**Google** ☐**Gold's Gym**

☐**General Dentist** _____ ☐**Other** _____
Dentist's Name

☐**By existing patient? Who?:** _____

Spouse Information

His / Her Name: _____ Birth date: _____/_____/_____ SS#:_____-_____-_____

Employer: _____ Cell #: (____)_____-_____Wk #: (____)_____-_____ Ext: ____

Emergency Information

Name of nearest Relative or Friend not living with you: _____ Relation:_____

Work #: (_____)_____ Home #: (_____)_____-_____ Cell #: (____)_____-_____

Dental Insurance Information

Dental Coverage: ___Yes ___No / Ins. Company: _____

Group #:_____ ID#: _____ Phone #: (_____)_____-_____

Insurance Co. Address: _____
City State Zip

Insured's Name: _____ Relation: _____ Insured's Birthdate: _____/_____/_____

SS#: _____-_____-_____ Insured's Employer: _____

Employer's Address: _____
City State Zip

Medical History

Physician: _____ Date of Last Visit: _____/_____/_____

CIRCLE Yes or No to the following (If Yes, please fill in details):

Yes No Are you taking any medication? _____
Yes No Are you allergic to any medication? _____
Yes No Do you have a history of a major illness? _____
Yes No Have you had any major operations? _____
Yes No Have there been any injuries to the face, mouth, teeth or chin? _____

CIRCLE any of the medical conditions below that you have had or currently have:

Abnormal Bleeding/Hemophilia	Epilepsy	Nervous Disorders	Tuberculosis
ADD/ADHD	Gastrointestinal Disorders	Herpes	Rheumatic Fever
Anemia	Handicap/Disability	Radiation/Chemotherapy	Sickle Cell
Asthma or Hayfever	Hearing Impairment	Kidney Problems	HIV/ AIDS
Cancer	Heart Murmur	Liver Problems	Low Blood Pressure
Congenital Heart Defect	Hepatitis/Liver problems	Mitral Valve Prolapse	High Blood Pressure
Stroke	Sinus Problems	Ulcers	Venereal Disease
Diabetes			

Are there any medical conditions we have not discussed that you feel we should be aware of? _____

_____

CIRCLE any allergic reactions to the following:

Yes	No	Asprin	Yes	No	Erthromycin	Yes	No	Penicillin
Yes	No	Codeine	Yes	No	Jewelry/Metals	Yes	No	Tetracycline
Yes	No	Dental Anesthetics	Yes	No	Latex	Yes	No	Other

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

_____

Release and Waiver

I authorize release of any information regarding my treatment to my dental and/or medical insurance company.

Signature _____ Date _____

I have read the above questions and understand them. I will not hold my orthodontist or any member of his/ her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my dentist of any changes in my medical or dental health.

Signature _____ Date _____

Dental History

Dentist: _____ Date of Last Visit: _____/_____/_____

What concerns you most about your teeth? _____

CIRCLE Yes or No to the following questions:

Yes No Are you presently in any dental pain? Explain: _____
Yes No Have you ever experienced any unfavorable reaction to dentistry?
Explain: _____
Yes No Have you ever lost or chipped any teeth?
Yes No Is any part of your mouth sensitive to temperature or pressure?
Yes No Do your gums bleed when you brush?

Yes No Do you have any type of thumb or tongue habit?

Yes No Are you a mouth breather?
Yes No Have you ever seen an orthodontist? If yes, who and when? _____

What is your attitude toward receiving orthodontic treatment?_____

Yes No Would you object to wearing orthodontic appliances (braces)?
Yes No Has anyone in your family received orthodontic treatment? If so, who? _____

How did they feel about the result?_____
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning?

Yes No Are you aware of your jaw clicking or popping? Explain: _____

Yes No Are you aware of clenching your teeth during the day?
Yes No Have you ever been told that you grind your teeth?
Yes No Do you have "tension" headaches?
Yes No Have you or the patient ever seen an orthodontist? If yes, who and when? _____
Yes No Have you ever experienced chronic ringing in your ears?
Yes No Are you aware that some appointments will be during school/work hours?_____
Yes No Are you pregnant?
Yes No Do you have any missing or extra permanent teeth?
Yes No Do you have any speech problems?

Your current dental health is (Please CHECK): _____ Good _____ Fair _____ Poor

Are you happy with the way your smile looks? ____ Yes _____ No

Acknowledgment of Privacy Policy

I, _____(please print first and last name), am aware that a copy of this office's Notice of Privacy Practices is available at request.

Benefits of Dentistry

Benefits of Dentistry: Aesthetics, Health and Function. Dentistry is a service that provides an improvement in the appearance of the teeth, in the general function of the teeth, and in general dental health. Maintaining good oral health outside of the dental office is a vital tool for each and every patient. I have read and understand this paragraph; I also understand that my diagnostic records and my name may be used for educational and promotional purposes. I have truthfully answered all the above questions and agree to inform this office of any changes in my medical or dental history. In addition, I authorize the doctors of Heavenly Dental Associates to perform a complete dental evaluation.

Signature: _____ Date: _____/_____/_____

HEAVENLY Dental Associates

Conveniently Serving Your Family in Conyers, Covington, Lithonia, and McDonough

www.SmilesByHeavenly.com

"Giving Your SMILE a Heavenly Touch!"