Medical History

Name _____

Physician_____ Preferred Pharmacy_____

Address_____ Phone_____

Are you taking any medications?_____
_____
Are using any OTC medications, herbal or nutritional supplements?_____
_____
Are you allergic to any medication?_____
Are you taking any bone strengthening medications?_____
Do you have a history of major illness?_____
Have you had any hospitalizations in the past 2 years?_____ for_____
If female: are you taking any hormones or birth control? _____
Are you pregnant or suspect that you are?_____

Please circle if you have had or currently have any of the following conditions:

Heart Defect or Heart Murmur
Congenital Heart Problems
Endocarditis
Mitral Valve Prolapse
Abnormal Bleeding/Hemophilia
High Blood Pressure
AIDS
Allergies
Anemia
Arthritis
Asthma or Hayfever
Bone Disorders
Chemotherapy
Diabetes
Dizziness
Drug Dependence
Epilepsy
Fainting
Gastrointestinal Disorders
GERD
Glaucoma
Hepatitis
Herpes
HIV Positive
Jaundice
Kidney Problems
Nervous Disorders
Organ Transplant
Pacemaker
Pneumonia
Prolonged Bleeding
Prolonged Cough
Psychiatric Treatment
Radiation Therapy
Rheumatic Fever
Sickle Cell Anemia
Stroke
Sinus Trouble
Thyroid Disease
Tuberculosis
Tumor or Cancer
Ulcers
Venereal Disease

Other condition(s) not listed here _____

Patient Information

Date_____

Patient name_____

Address_____

Home Phone _____ Cell/Mobile #_____

Marital Status_____ DOB_____ SSN#_____

DL#_____ E- Mail _____

Employer_____, Occupation_____

Work#_____

Spouse's Name_____

Employer_____ Work#_____

Emergency Contact Person_____

Relationship_____Phone#_____

Are you a student?_____ If so, what school?_____

If patient is a Minor, Give Parent's or Guardian's Name_____

How did you hear about our office?_____

Reason for your visit today?_____

How would you like us to confirm your appointments: Text E-mail Mail Phone

Are voice messages ok?_____

Responsible Party Information

Name_____
IF NOT SAME AS PATIENT

Address_____

Home Phone_____ Cell #_____ E-Mail_____

SSN#_____ DOB_____

Relationship to Patient_____

Employer_____ Work#_____

Please indicate how you prefer to pay for your dental treatment_____

Dental Insurance Information

Insured's Name_____ Relationship to patient_____

DOB_____ SSN#_____

Insurance
Company_____

Address_____

ID#_____

Is there additional Insurance?

Insured's Name_____ Relationship to patient_____

DOB_____ SSN#_____

Insurance
Company_____

Address_____

ID#_____

Dental History

Date of last dental visit_____ Previous Dentist_____

What concerns you most about your teeth? _____

_____

Are you in any dental pain?_____

Have you ever experienced any unfavorable reaction to dentistry? _____

Do you have any chipped or broken teeth?_____

Are you happy with your smile?_____

Are you a mouth breather? _____

Do you have problems with "bad" breath? _____

Do your gums bleed when you brush?_____

Do you have any loose or shifting teeth (change in position)?_____

Have you ever been treated for "gum disease"? _____

Have there been any injuries to your face, mouth, or teeth? _____

Is any part of your mouth sensitive to temperature or pressure? _____

Do your teeth or jaws hurt in the morning?_____

Have you ever been told that you grind/clench your teeth? _____

Have you experienced chronic ringing in the ears or tension headaches?_____

Have you had any cold sores on your lips, gums, tongue, or body?_____

Are you allergic to: Penicillin __ Codeine__ Local Anesthetic__ Latex __

Are you taking any medications for osteoporosis? i.e. Boniva, Fosamax

Signature_____Date_____