Medical/Dental History Form **Date: ____________________**

Although in Dentistry we primarily treat the mouth and all of its structures, the oral cavity is connected to the rest of the body and acts as the gateway to many of its organ systems. Health problems that you may have or medications that you may be taking could have an important interrelationship with the dentistry you will receive. Therefore, it is important that you answer all of the pertinent questions. Thank you.

Patient Name: ____ Date of Birth: __________________________________

[ ] Mr. [ ] Mrs. [ ] Miss [ ] Ms. [ ] Dr. Email: ____

Home Address: ____ City: ____

State: __________________ Zip code: ____________________

Phone Numbers:
Home: ________________________ Cell: ________________________ Work: ___________________________________

[ ] Male [ ] Female [ ] Other Marital Status: ____________ Social Security # ___________________________________

Drivers License # ____ State Issued: ___________________________________

Employer Name: ____ Occupation: ___________________________________

Person responsible for the account is [ ] Self [ ] Spouse [ ] Other ____

Emergency Contact: ______________________________________ Phone: ____

Relationship to Patient: ___________________________________

Insurance Information:
Are you covered by dental insurance [ ] Yes [ ] No

Subscriber Name: ________________________________ Relation to Patient: ____________________________________

Subscriber Date of Birth: __________________________

Address and phone (if different from Patient): ____

____

Insurance Company and Claims Address: ____

Subscriber Employed by: _________________________________ Business Phone: ________________________________

Subscriber ID # (listed on insurance card): _________________________ Group # _______________________________

Whom may we thank for referring you? ____

Patient Name ______________________________________ **Page 2**

Oral Health

Reason for today's visit: ____

Date of last dental care and name of former dentist (if you are a new patient to our practice)

____

Check [√] if you have had problems with any of the following:

Bad breath
Loose teeth or broken fillings
Sensitivity when biting
Grinding teeth
Sensitivity to sweets
Food collection between teeth
Sensitivity to hot
Clicking or popping jaw
Sensitivity to cold
Bleeding gums
Periodontal treatment
Sores or growths in your mouth
Root canals
Cold sores/fever blisters/herpes

Is there a specific dental problem that you currently have that is not listed above? _______________________________

____

How often do you floss? ______________________ How often do you brush? __________________________________

What type of toothbrush do you currently use? ____

Would you be interested in purchasing an electronic toothbrush? [ ] Yes [ ] No

Would you be interested in straighter teeth? [ ] Yes [ ] No

Would you be interested in whiter teeth [ ] Yes [ ] No

Reducing snoring? [ ] Yes [ ] No

Personal Health

How would you rate your current health? [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Name and location of your current physician: ____

Date of your last physical exam: _____________________ Date of last blood work _______________________________

Medications/Supplements: Please list all prescription and non-prescription medications, injections, infusions, vitamins, home remedies, herbs and topical creams:

_____________________________ _____________________________ _____________________________

_____________________________ _____________________________ _____________________________

_____________________________ _____________________________ _____________________________

Allergies or reactions to medications: ____

Do you have any food allergies or food sensitivities? [ ] Yes [ ] No

If yes, please explain: ____

Surgical/Hospitalization history: Please list all operations with the dates when they occurred:

____

____

Please indicate whether you have had any of the following medical problems and/or family history:

	You	Family		You	Family
Periodontal Disease	[ ]	[ ]	Artificial Heart Valve	[ ]	[ ]
Dental Infections	[ ]	[ ]	Heart Arrhythmia	[ ]	[ ]
Bacterial Endocarditis	[ ]	[ ]	Heart Valve Problem	[ ]	[ ]
Pacemaker	[ ]	[ ]	Rheumatoid Arthritis	[ ]	[ ]
Heart Disease	[ ]	[ ]	Kidney Disease	[ ]	[ ]
Stroke	[ ]	[ ]	Kidney Stones	[ ]	[ ]
High Cholesterol	[ ]	[ ]	Gallbladder Stones	[ ]	[ ]
High Blood Pressure	[ ]	[ ]	Pancreatic Disease	[ ]	[ ]
Pre-diabetes	[ ]	[ ]	Lupus	[ ]	[ ]
Diabetes	[ ]	[ ]	Hepatitis Type _______	[ ]	[ ]
Mini-Stroke or TIA	[ ]	[ ]	Gout	[ ]	[ ]
Atrial Fibrillation	[ ]	[ ]	Sjogren's Syndrome	[ ]	[ ]
Poor blood flow to extremities	[ ]	[ ]	Autoimmune Disorder	[ ]	[ ]
Fibromyalgia	[ ]	[ ]	Thyroid Problems	[ ]	[ ]
Emphysema/COPD	[ ]	[ ]	Depression	[ ]	[ ]
Bleeding/Clotting Problems	[ ]	[ ]	Anxiety/Panic Attacks	[ ]	[ ]
Blood Transfusions	[ ]	[ ]	Migraine Headaches	[ ]	[ ]
Anemia	[ ]	[ ]	Osteopenia/Osteoporosis	[ ]	[ ]
High Red Blood Cell Count	[ ]	[ ]	Blood Clot (legs,arms,lungs)	[ ]	[ ]
Leukemia	[ ]	[ ]	Alcoholism	[ ]	[ ]
Abnormal Platelet Count	[ ]	[ ]	Drug Use	[ ]	[ ]
Stomach Ulcers	[ ]	[ ]	Mental Disability	[ ]	[ ]
Chronic Heartburn	[ ]	[ ]	Sleep Disorder/Sleep Apnea	[ ]	[ ]
Post-Traumatic Stress Syndrome	[ ]	[ ]	Joint Replacement	[ ]	[ ]
STD	[ ]	[ ]	History of HIV or AIDS	[ ]	[ ]
Epilepsy/Seizures	[ ]	[ ]	Other ___________________________		
Cancer	[ ]	[ ] Explain:_______________________________			

Premedicate with antibiotic prior to dental treatment? [ ] Yes Why? ____

Social History

Tobacco Use

Cigarettes [ ] Never [ ] Quit (date you quit) _______________ [ ] Current how much per day___________

Other tobacco (check all answers that apply): [ ] Pipe [ ] Cigar [ ] Chewing tobacco

[ ] E-Cigarettes [ ] Marijuana

Number of years you've used this tobacco: ____

Are you interested in quitting? [ ] Yes [ ] No Have you tried to quit in the past? [ ] Yes [ ] No

How many times have you tried to quit? ___________ What methods have you tried? _______________________________

Are you exposed to second-hand smoke? [ ] Yes [ ] No If yes, for how long? ___________________________________

Alcohol Use

Do you drink alcohol? [ ] Yes [ ] No

If yes, how many drinks do you consume per week? ____________________Alcohol type? __________________________

Does your alcohol consumption have you or others concerned? [ ] Yes [ ] No

Signature: ____ Date: ____________________________

Signature of Parent or Guardian: ____