Date: ________________

Medical/Dental History

PERSONAL HISTORY

Name: ____Date of Birth: ______________Gender: ☐ M ☐ F
Address: ____________________________________City:__________ ______State:________Zip Code: ______
Home Phone: ________________Cell Phone: __________________Business Phone: __________________________
What is the best way to confirm your appointment? Check all that applies: Home Phone___ Business Phone ☐ E-Mail ☐ Cell Phone ☐ Text ☐
Email: ____Height:______Weight:______Marital Status: ______
Employed by: ______________________________________ Position: ____________________________
Address: ____City:__________________State:________
Name of Spouse: ________________________Employed by:_________________________Phone:__________
Dentist's Name:________________________Address:___________________________Phone:__________
Who Referred by: ____
Physician's Name:____________________________Date of Last Physical Exam:______Reason:________________

Emergency Information:

Contact Name:____________________________________Address:__________________________________
Relationship: ________________________________ _ ____Phone:________________ __________________
If any family member(s) have been treated in our office, please list family member(s):_________________________________
____

PRIMARY DENTAL INSURANCE INFORMATION:

Name of Insured: ______________________________________Relationship to Patient:______Birthdate:__________
SS#/ID#:_________________Date Employed:_____Name of Employer:____________________Work#:____________
Address of Employer:___________________________________City:_____________________State:__________
Insurance Company Name:_______________________________________Group#:___________Union Local#_______
Insurance Company Address:______________________________City:___________State:______Zipcode:_______
Do you have a secondary dental insurance plane? ☐Y or ☐N If yes, completes the following:
Name of Insured: ______________________________________Relationship to Patient:______Birthdate:__________
SS#/ID#:____ Date Employed:____________________________
Name of Employer:_____________________________________Work Phone:________________________________
Address of Employer:___________________________________ City:___________________State:____________
Insurance Company Name:_______________________________________Group#:_______Union Local#:__________
Insurance Company Address:______________________________City:___________State:______Zipcode:_______

MEDICAL HISTORY:

List medications that you are presently taking and for what medical condition (i.e. Novasc-High Blood Pressure)
____
____
____
Do you have Osteoporosis? ☐Y or ☐N Has your Osteoporosis ***EVER*** been treated with medication? ☐Y or ☐N If so, for how long ____________
Please provide any and all medication for your Osteoporosis: ____
Do you use Tobacco? (i.e., cigarette, pipe and/or vape) ☐Y or ☐N If yes, complete the following: How much? __________For long? _______
Do you take aspirin daily? If yes, _________mg or ☐N Do you have a latex allergy? ☐Y or ☐N
Do you take antibiotics routinely prior to dental care? Y or N If yes, with what antibiotic: ______________________________
Pharmacy preference: ____
List all medications you are allergic to (i.e., Codeine, Aspirin, Penicillin, Ibuprofen)
____
____
____
Are you on any pain management program? ☐Y or ☐N If so, list all programs, medications and the prescribing doctor's name:
____
____
____

Check any of the following conditions that you have had or have at present.

- ☐ Diabetes
- ☐ Heart Failure
- ☐ A-Fib
- ☐ Heart Disease or Attack
- ☐ Angina Pectoris
- ☐ High Blood Pressure
- ☐ Heart Murmur
- ☐ Rheumatic or Scarlet Fever
- ☐ Yellow Jaundice
- ☐ Mitral Valve Prolapse
- ☐ Artificial Heart Valve
- ☐ Heart Pacemaker
- ☐ Heart Surgery
- ☐ Artificial Joint or Limb Replacement
- ☐ Lupus
- ☐ Sexually Transmitted Disease(s)
- ☐ Stroke
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Reflux Disease
- ☐ Epilepsy or Seizures
- ☐ Multiple Sclerosis (MS)
- ☐ Hormone Replacement Therapy
- ☐ Emphysema
- ☐ Cough
- ☐ Tuberculosis (TB)
- ☐ Asthma
- ☐ Hay Fever
- ☐ Sinus Trouble
- ☐ Congenital Heart Lesions
- ☐ Thyroid Disease
- ☐ Radiation Therapy
- ☐ Chemotherapy
- ☐ Arthritis
- ☐ Rheumatism
- ☐ Fibromyalgia
- ☐ Organ Transplant
- ☐ Kidney Trouble
- ☐ Pain in Jaw Joints
- ☐ Cortisone Medicine
- ☐ Ulcers
- ☐ Fainting or Dizzy Spells
- ☐ Shingles
- ☐ Blood Transfusion
- ☐ HIV Positive
- ☐ AIDS
- ☐ Hepatitis A (Infectious)
- ☐ Hepatitis B (Serum)
- ☐ Hepatitis C
- ☐ Liver Disease
- ☐ Allergies or Hives
- ☐ Hemophilia
- ☐ Anemia
- ☐ Cold Sores
- ☐ Canker Sores
- ☐ Crohn's Syndrome
- ☐ Sjogren's Syndrome
- ☐ Bruise Easily
- ☐ Sickle Cell Disease
- ☐ Eating Disorders
- ☐ Nervousness
- ☐ Psychiatric Treatment
- ☐ Memory Issues
- ☐ Cancer – Describe____
- ☐ Other conditions not listed: ____

____

Check:

Are you having pain or discomfort at this time? ________________________________ ☐Yes or ☐No
Do you feel very nervous about having dental treatment?___________________________ ☐Yes or ☐No
Have you ever had a bad experience in the dental office? ___________________________ ☐Yes or ☐No
Have you been a patient in the hospital for a major illness in the past two years? ______________ ☐Yes or ☐No
Have you been under the care of a medical doctor in the past two years? __________________ ☐Yes or ☐No
Have you ever had any excessive bleeding requiring special treatment?____________________ ☐Yes or ☐No
When you walk upstairs or take a walk, do you have to stop because of pain in your chest?
Shortness of breath or because you are very tired?_________________________________ ☐Yes or ☐No
Do your ankles swell during the day? ______________________________________ ☐Yes or ☐No
Do you use more than 2 pillows to sleep? ____________________________________ ☐Yes or ☐No
Have you lost or gained 10 pounds in the past year? _______________________________ ☐Yes or ☐No
Do you ever wake up from sleep short of breath? _______________________________ ☐Yes or ☐No
Are you on a special diet? ____ ☐Yes or ☐No
Have you been out of the United States in the last two years? ___________________________ ☐Yes or ☐No

Women

Are you pregnant? ____ ☐Yes or ☐No
Are you taking any birth control?_______________________________________ ☐Yes or ☐No
Do you anticipate becoming pregnant? _____________________________________ ☐Yes or ☐No

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if any of my medicines change, I will inform the doctor of dentistry at the next appointment without fail.

Professional care is provided to you, our patient, and it is your responsibility to pay any balance incurred regardless of insurance coverage.

Date_________________________ Signature of Patient, Parent or Guardian____