



## Medical & Dental History Form

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Chart #.   
FOR OFFICE USE ONLY

Patient Name:      
Last First MI Preferred Name

Title:  Gender:  Male  Female Family Status:  Married  Single  Child  Other  
Mr/Ms/Mrs/etc

Birth Date:  SS #:  Prev. Visit:

Email Address:  Best time to call:

Phone:        
Home Work Ext Mobile Fax Other

Address:    
    
City State Zip Code

Would you consider yourself to be in fairly good health?  
 Yes  No

Within the past year, have there been any changes in your general health?  
 Yes  No

Do you have a pacemaker, an artificial heart valve, or been diagnosed with mitral valve prolapse?  
 Yes  No

What is the date (or approximate date) of your last medical exam?



Your Primary Care Physician's name, address, & phone number:

Are you taking any medication or substances?

- Yes     No

If you have answered yes, please list:

Please mark any of the following to indicate Yes in response to the question:

- Have you ever had complications following dental treatment?
- Are you currently under the care of a physician due to a specific condition?
- Have you been hospitalized within the last 5 years due to a surgery or illness?
- Are you currently taking any prescription or non-prescription medications?
- Do you require the use of corrective lenses (contacts or glasses)?
- Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

If any of the previous questions are marked, please explain:

WOMEN ONLY: Are you pregnant?

- Yes     No

If Yes, when is the due date? \_\_\_\_\_



Have you ever had a serious illness or major surgery? If so please explain...

Have you ever taken Fosamax, Zometa, Aredia or any other oral or intravenous treatment (bisphosphonates) for bone tumors, excessive calcium in your blood or osteoporosis?

Yes     No

Please indicate if you have experienced any of the following:

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> *PreMed              | <input type="checkbox"/> Acid Reflux          | <input type="checkbox"/> Allergies              | <input type="checkbox"/> Amoxicillin Allergy  |
| <input type="checkbox"/> Anemia               | <input type="checkbox"/> Antidepressants      | <input type="checkbox"/> Antihistamines Allergy | <input type="checkbox"/> Arthritis            |
| <input type="checkbox"/> Artificial Joints    | <input type="checkbox"/> Asthma               | <input type="checkbox"/> Benzocaine             | <input type="checkbox"/> Bisphosphonates      |
| <input type="checkbox"/> Blood Thinners/other | <input type="checkbox"/> Blood thinners       | <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Chemotherapy         |
| <input type="checkbox"/> Clindamycin Allergy  | <input type="checkbox"/> Codeine Allergy      | <input type="checkbox"/> Dementia               | <input type="checkbox"/> Diabetes             |
| <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Down Syndrome        | <input type="checkbox"/> Drug/AL. addictions    | <input type="checkbox"/> Epilepsy             |
| <input type="checkbox"/> Erythromycin Allergy | <input type="checkbox"/> Excessive Bleeding   | <input type="checkbox"/> Fainting               | <input type="checkbox"/> Glaucoma             |
| <input type="checkbox"/> Hay Fever            | <input type="checkbox"/> Heart Disease        | <input type="checkbox"/> Heart Murmur           | <input type="checkbox"/> Hepatitis            |
| <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> HIV                  | <input type="checkbox"/> Hyperthyroid           | <input type="checkbox"/> Ibuprofen Allergy    |
| <input type="checkbox"/> Jaundice/liver dis.  | <input type="checkbox"/> Kidney Disease       | <input type="checkbox"/> Latex Allergy          | <input type="checkbox"/> Local Anes. Allergy  |
| <input type="checkbox"/> Mental Disorders     | <input type="checkbox"/> Motrin allergy       | <input type="checkbox"/> Multiple Sclerosis     | <input type="checkbox"/> Nervous Disorders    |
| <input type="checkbox"/> Other                | <input type="checkbox"/> Penicillin Allergy   | <input type="checkbox"/> Prednisone Allergy     | <input type="checkbox"/> Pregnancy            |
| <input type="checkbox"/> Radiation Treatment  | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Rheumatic Fever        | <input type="checkbox"/> Rheumatism           |
| <input type="checkbox"/> Sinus Problems       | <input type="checkbox"/> Smoker/Chew          | <input type="checkbox"/> Steroids Allergy       | <input type="checkbox"/> Stop Coumidin        |
| <input type="checkbox"/> Stroke               | <input type="checkbox"/> Sulfa allergy        | <input type="checkbox"/> Talwin Allergy         | <input type="checkbox"/> Tetracycline allergy |
| <input type="checkbox"/> Tuberculosis         | <input type="checkbox"/> Tumors               | <input type="checkbox"/> Ulcers                 | <input type="checkbox"/> Venereal Disease     |



Do you require antibiotics before dental treatment?

- Yes     No

Have you ever had or have pain in your jaw joint?

- Yes     No

Have you ever had cold sores or fever blisters?

- Yes     No

Do you bruise easily?

- Yes     No

Have you ever bled excessively after being cut or injured?

- Yes     No

Have you had psychiatric treatment?

- Yes     No

Have you taken any prescription drugs Fenfluramine, Fenfluramine combined with Phentermine (Fen-Phen), Dexfenfluramine (Redux), or other weight loss products?

- Yes     No

Have there been injuries to your face, mouth or chin?

- Yes     No

Do you have any disease, condition or problem not listed? If so explain...

Is there anything else we should know about your health that we have not covered in this form?



To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

**Authorization**

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian:

Signature: \_\_\_\_\_

Date:

Relationship to Patient:

Response Date: