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 how 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	☐ Hormone Replacement Therapy	☐ Blood Transfusion
☐ Heart Failure	☐ Emphysema	☐ HIV Positive
☐ A-Fib	☐ Cough	☐ AIDS
☐ Heart Disease or Attack	☐ Tuberculosis (TB)	☐ Hepatitis A (Infectious)
☐ Angina Pectoris	☐ Asthma	☐ Hepatitis B (Serum)
☐ High Blood Pressure	☐ Hay Fever	☐ Hepatitis C
☐ Heart Murmur	☐ Sinus Trouble	☐ Liver Disease
☐ Rheumatic or Scarlet Fever	☐ Congenital Heart Lesions	☐ Allergies or Hives
☐ Yellow Jaundice	☐ Thyroid Disease	☐ Hemophilia
☐ Mitral Valve Prolapse	☐ Radiation Therapy	☐ Anemia
☐ Artificial Heart Valve	☐ Chemotherapy	☐ Cold Sores
☐ Heart Pacemaker	☐ Arthritis	☐ Canker Sores
☐ Heart Surgery	☐ Rheumatism	☐ Crohn's Syndrome
☐ Artificial Joint or Limb Replacement	☐ Fibromyalgia	☐ Sjogren's Syndrome
☐ Lupus	☐ Organ Transplant	☐ Bruise Easily
☐ Sexually Transmitted Disease(s)	☐ Kidney Trouble	☐ Sickle Cell Disease
☐ Stroke	☐ Pain in Jaw Joints	☐ Eating Disorders
☐ Cataracts	☐ Cortisone Medicine	☐ Nervousness
☐ Glaucoma	☐ Ulcers	☐ Psychiatric Treatment
☐ Reflux Disease	☐ Fainting or Dizzy Spells	☐ Memory Issues
☐ Epilepsy or Seizures	☐ Shingles	
☐ Multiple Sclerosis (MS)		

☐ 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_______________________________________