

Patient Medical/Dental History Form

NAME: _____

DATE: _____

MEDICAL HISTORY

Please Circle Appropriate Response:

NO YES **Are you in good general health?**
NO YES Are you now taking any drugs or medications?
Which ones? _____

NO YES Are you allergic to any medications?
Which ones? _____

Family Doctor: _____
Phone: _____

NO YES Would you object to our office contacting your family doctor in regard to any medical problem that may arise?

NO YES Have you ever received local anesthesia (Novocaine or Xylocaine) by a dentist or doctor?

NO YES Have you ever received general anesthesia?

NO YES Have you ever had any adverse reaction to either local or general anesthesia?
Please describe _____

NO YES Do you take blood thinners?
Which ones? _____

NO YES Do you take vitamins regularly?
Which ones? _____

NO YES Do you take vitamins containing Vitamin E?

NO YES Do you take aspirin products or anti-inflammatory medicines or headache medicines?
Which ones? _____

NO YES Do you exercise regularly?

PLEASE LIST ALL PREVIOUS SURGERIES AND DATES:

DO ANY FAMILY MEMBERS HAVE: (Circle if yes)

Heart trouble	Tuberculosis
Excessive scarring	Excessive bleeding tendency
Diabetes	Psychiatric or "nerve" problems
Adverse reactions to anesthesia	

HAVE YOU HAD:

NO	YES	Blood pressure or related problems
NO	YES	Liver, gallbladder, problems
NO	YES	"yellow Jaundice", Hepatitis problems
NO	YES	Heart trouble
NO	YES	Kidney disease
NO	YES	Diabetes
NO	YES	Stomach problems, indigestion or ulcers
NO	YES	Bleeding tendency or excessive bruising
NO	YES	Any part of your body paralyzed or numb
NO	YES	Psychiatric consultation
NO	YES	Epilepsy-convulsions or seizures
NO	YES	Broken bones of the face, neck, jaw or back
NO	YES	Back trouble
NO	YES	Abnormal chest x-rays
NO	YES	Abnormal Electrocardiogram (ECG)
NO	YES	Asthma or other respiratory problems
NO	YES	Any medical treatment for nervous condition
NO	YES	Excessive scarring
NO	YES	Tuberculosis
NO	YES	Thyroid problems
NO	YES	Any other illnesses. If so please list:
NO	YES	A gain or loss of more than 15 pounds in your body weight.
NO	YES	Abdominal or inguinal hernia
NO	YES	History of blood clots in legs or lungs
NO	YES	History of legs swelling
NO	YES	Glaucoma, cataracts
NO	YES	Dry eyes
NO	YES	Herpes or Cold Sores

Other: _____

DO YOU:

NO	YES	Wear contact lenses
NO	YES	Have dentures, false teeth, caps or bridges
NO	YES	Smoke? How much? _____
NO	YES	Drink alcohol? How much? _____
NO	YES	Think you are pregnant? Date of last menstrual period _____
NO	YES	Have any contagious or infectious condition
NO	YES	Have you been exposed directly or indirectly to any one with HIV (AIDS)

The above information is strictly confidential

Patient Signature

Date

Witness Signature

Date

Patient Medical/Dental History Form

PATIENT DENTAL HISTORY

What is your reason for seeking care at this time: _____

Do you have regular dental checkups? When was your last dental exam: _____

Have you had any dental x-rays completed within the last 5 years: _____

Do you have any pain or discomfort now? What: _____

Do your gums bleed? _____ Have you had surgery performed on your gums? _____

Have you ever had a root canal? _____ Have you ever worn braces? _____ Do you wear Dentures? _____

Do you grind your teeth? _____ Have you ever had any trauma to your face or mouth? _____

Do you floss? How often _____ How many times a day do you brush your teeth? _____

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

I also understand that I am responsible for any account balance and payment in full is expected at time of service, unless prior arrangements have been made. As a courtesy to our patients, your insurance claims will be completed for you. However, Insurance is between you and your insurance company. You are still responsible for any unpaid or denied claims.

All information is HIPPA compliant and will only be disclosed for medical or dental treatment.

Signature of Patient/Parent or Guardian

Date: _____