Medical and Dental History

Last Name: ____________________ First Name: ____________________ Birthdate: ________________

Primary Care Doctor and Date of Last Visit: ____

Please list all medications you are currently taking:

____

____

____

____

Please answer the following questions.

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

Do you see a specialist for any reason? ☐ Yes ☐ No

If so, please list doctor, specialty, and ph. number: ____

____

Are you allergic to any medication? ☐ Yes ☐ No

Please list ALL KNOWN allergies: ____

____

Are you diabetic? ☐ Yes ☐ No If so, what is your most recent A1C? ________________

Do you now or have you ever taken osteoporosis (bone strengthening) medications? ☐ Yes ☐ No

Are you currently taking BLOOD THINNER medication? ☐ Yes ☐ No

Do you have any HEART VALVE REPLACEMENTS or ARTIFICIAL JOINTS? ☐ Yes ☐ No

Have you been hospitalized within the last 5 years due to surgery/illness? Please Explain.

____

Do you use tobacco? ________________________________

Do you snore or have you been told that you stop breathing while sleeping? ☐ Yes ☐ No ☐ Occassionally

Do you currently use a CPAP? If so, for how long? ____

Are you currently under the care of a physician due to a specific condition? ☐ Yes ☐ No

WOMEN ONLY: Are you pregnant or nursing? ☐ Yes ☐ No

Please indicate if you have experienced any of the following:

Y	N	Condition	Y	N	Condition
☐	☐	Autism Spectrum Disorder	☐	☐	Hepatitis
☐	☐	Chemotherapy/Radiation	☐	☐	HIV
☐	☐	Cancer	☐	☐	Epilepsy
☐	☐	Excessive Bleeding	☐	☐	Dye Allergy
☐	☐	Thyroid Disorder	☐	☐	Milk Allergy
☐	☐	Heart Conditions	☐	☐	Lung Disease
☐	☐	High Blood Pressure	☐	☐	Stomach Problems/Ulcers
☐	☐	Asthma	☐	☐	Rheumatic Fever
☐	☐	Migraines or Headaches	☐	☐	Stroke
☐	☐	Developmental Delay	☐	☐	Frequent Urination at Night
☐	☐	Behavioral Disorder	☐	☐	Insomnia

Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

____

____

Please answer each question regarding your dental health.

When was your last visit to the dentist (if to a different office)? ______________________

How often do you brush your teeth?

☐ 3 (+) a day ☐ Twice a day ☐ Once a day ☐ Weekly ☐ Seldom

How often do you floss your teeth?

☐ 1 (+) a day ☐ 2-6 times a week ☐ 1-6 times a month ☐ Seldom ☐ Never

Do you have dental anxiety? ☐ Yes ☐ No

Do you currently have any dental implants, dentures, or partials? ☐ Yes ☐ No

Do your gums bleed when brushing or flossing? ☐ Yes ☐ No ☐ Sometimes

Do any of your teeth experience sensitivity to cold or hot temperatures? ☐ Yes ☐ No ☐ Sometimes

Are any of your teeth currently causing you pain? ☐ Yes ☐ No

Do you grind your teeth (either awake or during sleep)? ☐ Yes ☐ No ☐ Sometimes

Are any of your teeth loose or are you concerned about any teeth loosening? ☐ Yes ☐ No

Do you ever experience TMJ or jaw pain? ☐ Yes ☐ No

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

____

____

If you could change anything about your mouth, teeth, or smile what would it be?

____

☐ Please check box to show that to the best of my knowlege all of the preceding information I have given is true and correct. If there is ever a change in my health, I will inform the office at my next dental appointment without fail.

AUTHORIZATION

I hearby 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 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).

All forms to be completed and signed by patient, parent, or guardian.

Signature: ______________________________ Date: __________

Staff Reviewed:(please initial) ☐ Date: __________