Medical History / Dental History

Patient Name: Birth Date: Date Created:

For Office Use...

Today's Radial Blood Pressure: Today's Pulse: Today's CC:

Disclaimer

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important relationship with the dentistry you will receive. Thank you for answering the following questions.

Do you have a primary care physician? (name, date of last visit)	Yes No	If yes
Do you see a specialist physician? (name, date of last visit)	Yes No	If yes
Do you have an artificial joint? (type, year of surgery, surgeon)	Yes No	If yes
Have you ever been diagnosed with cancer? (type, year diagnosed)	Yes No	If yes

Cancer Treatment received.....

☐ Chemotherapy ☐ Radiation ☐ Surgery

Have you ever had a serious head or neck injury?	Yes No	If yes
Have you ever been hospitalized or had a major operation other than previously listed?	Yes No	If yes
Do you currently use tobacco? (Please list the type.)	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you taking any medications, drugs, pills, or supplements? (Please list or have photocopied.)	Yes No	If yes

Women: Are you...

☐ Pregnant? ☐ Trying to get pregnant? ☐ Taking oral contraceptives?

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes No	Diabetes	Yes No	Heart Attack/Failure	Yes No	Liver Disease	Yes No
Artificial Heart Valve	Yes No	Drug Addiction	Yes No	Hemophilia	Yes No	Lung Disease	Yes No
Asthma	Yes No	Epilepsy or Seizures	Yes No	Hepatitis B or C	Yes No	Psychiatric Care	Yes No
Chest Pains	Yes No	Excessive Bleeding	Yes No	High Blood Pressure	Yes No	Stroke	Yes No
Congenital Heart Disorder	Yes No	Fainting or Dizziness	Yes No	Kidney Problems	Yes No	Tuberculosis	Yes No
Dementia	Yes No	Frequent Headaches/Migraines	Yes No				

Have you ever had any serious illness not listed	Yes No	If yes

Are you allergic to any of the following?

☐ Acrylic	☐ Codeine	☐ Local Anesthetics	☐ Penicillin
☐ Aspirin	☐ Latex	☐ Metal	☐ Sulfa Drugs

Other Drug Allergies?	Yes No	If yes

Are you having discomfort at this time?	Yes No	If yes
Have you ever had a problem associated with any previous dental care?	Yes No	If yes
Is there anything you would change with your smile?	Yes No	If yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

RESPONSIBILITY OF PAYMENT AND DENTAL INSURANCE

To avoid any misunderstanding regarding your dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that the patients are personally responsible for payment of fees. We do not render services on the basis that the insurance companies will pay our fees. We will assist you in filing insurance forms. Payment is due when services are rendered unless other arrangements have been made. I hereby authorize payment of the dental benefits directly to the dental provider. I agree to be responsible for payment for services which are not paid by my dental benefit plan. I authorize release of information relating to insurance claims.

Signature of Patient, Parent or Guardian:

X Date:_____