

Medical History / Dental History(2022)

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.

Have you had any changes to your health in the past year (s)? Yes No If yes

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

Has a physician recommended you take antibiotics prior to your dental treatment? 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

Do you use controlled substances (drugs)? 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

Are you on a blood thinner? Yes No If yes

Are you pregnant? If yes, how many weeks? Yes No If yes

Women: Are you...

Are you nursing? Trying to get pregnant? Taking oral contraceptives?

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

Infective Endocarditis <input type="radio"/> Yes <input type="radio"/> No	Chronic Pain <input type="radio"/> Yes <input type="radio"/> No	Fainting or Dizziness <input type="radio"/> Yes <input type="radio"/> No	Mental Health Disorder <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches/Migraines <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No
AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Recurrent Infections <input type="radio"/> Yes <input type="radio"/> No
Acid Reflux <input type="radio"/> Yes <input type="radio"/> No	Dementia <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Development Disorder <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Autoimmune Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Sleep Disorder <input type="radio"/> Yes <input type="radio"/> No
Breathing Problems <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Eating Disorder <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No

Have you ever had any serious illness not listed above? 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

Is there a specific reason for today's visit? Yes No If yes

Are you having discomfort at this time? Yes No If yes

Is there anything you would change with your smile? Yes No If yes

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.

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: _____