Medical History

Personal Physician

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name: ______________________

Address: ______________________

Phone #: (______) ______________ Date of Last Visit: ______________

Physical Health

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician?

Please Explain: ______________________

Do you smoke or use any form of tobacco? ❑ Yes ❑ No

For Women:

Are you taking birth control pills? ❑ Yes ❑ No Are you pregnant? ❑ Unsure ❑ Yes ❑ No Week#: ____ Are you nursing? ❑ Yes ❑ No

Are you allergic to any of the following?

❑ Aspirin ❑ Codeine ❑ Erythromycin ❑ Latex ❑ Sedatives ❑ Tetracycline
❑ Barbiturates ❑ Dental Anesthetics ❑ Jewelry/Metals ❑ Penicillin ❑ Sulfa Drugs ❑ Other

Additional allergies? ______________________

Do you take any of the following?

❑ Acetaminophen ❑ Aspirin ❑ Cold Remedies ❑ Nitroglycerin ❑ Thyroid Medicine
❑ Antibiotics ❑ Blood Thinners ❑ Digitalis/Heart Medication ❑ Recreational Drugs ❑ Tranquilizers
❑ Antihistamines ❑ Blood Pressure Medication ❑ Insulin/Diabetes Drugs ❑ Steroids/Cortisone

Have you ever taken Phen-Fen (also known as Redux or Pondimin? ❑ Yes ❑ No

Please list additional prescription, over-the-counter drug, herbal remedies, or vitamins: ______________________

Are you experiencing or have you experienced the following?

❑ Abnormal Bleeding ❑ Colitis ❑ Headaches ❑ Liver Disease ❑ Shingles
❑ Alcohol Abuse ❑ Congenital Heart Disease ❑ Heart Attack ❑ Low Blood Pressure ❑ Sickle Cell Disease
❑ Anemia ❑ Diabetes ❑ Heart Murmur ❑ Lupus ❑ Sinus Problems
❑ Arthritis ❑ Difficulty Breathing ❑ Heart Surgery ❑ Mitral Valve Prolapse ❑ Steroid Therapy
❑ Artificial Bones/Joints ❑ Drug Abuse ❑ Hemophilia ❑ Pacemaker ❑ Stroke
❑ Artificial Valves ❑ Emphysema ❑ Hepatitis ❑ Persistent Cough ❑ Thyroid Problem
❑ Asthma ❑ Epilepsy ❑ Herpes ❑ Psychiatric Problems ❑ Tonsillitis
❑ Blood Transfusion ❑ Fainting Spells ❑ High Blood Pressure ❑ Radiation Treatment ❑ Tuberculosis (TB)
❑ Cancer ❑ Fever Blisters ❑ HIV+/AIDS ❑ Rheumatic Fever ❑ Ulcers
❑ Chemotherapy ❑ Glaucoma ❑ Hospitalization ❑ Scarlet Fever ❑ Venereal Disease
❑ Chicken Pox ❑ Hay Fever ❑ Kidney Problems ❑ Seizures

List any serious medical conditions you have experienced: ______________________

Dental History

Why have you come to the dentist today? ______________________

Dental Health

How would you rate your dental health? ❑ Good ❑ Fair ❑ Poor

Are you currently in pain? ❑ Yes ❑ No

Are you experiencing or have you ever experienced pain or discomfort in your jaw joint (TMJ/TMD)? ❑ Yes ❑ No

Do your gums ever bleed? ❑ Yes ❑ No

Do your gums ever itch? ❑ Yes ❑ No

Have you had periodontal disease? ❑ Yes ❑ No

Have you had problems with previous dental work? ❑ Yes ❑ No

Do you have mobility in your teeth? ❑ Yes ❑ No

Are your teeth sensitive to heat/cold? ❑ Yes ❑ No

Do you still have your wisdom teeth? ❑ Yes ❑ No

If yes, why? ______________________

Hygienic Routine

Do you floss daily? ❑ Yes ❑ No

Do you brush daily? ❑ Yes ❑ No

Type of toothbrush bristles? ❑ Hard ❑ Med. ❑ Soft

How long do you use a toothbrush before replacing it? ____________

Do you use anything in addition to brush and floss? ❑ Yes ❑ No

If yes, what? ______________________

Dentist History

Previous/Present Dentist: ____________ Last Dental Cleaning: ____
(Please Circle)

Why did you leave your previous dentist? ______________________

What did you like most & least about any dentist you've seen?

____

Would you like to change anything about your smile? ______________________

Authorizations

I affirm that the information I have provided is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need. My method of payment will be ______________________.

____
Signature Date

PAYMENT IS DUE AT TIME OF SERVICE

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I certify that I am covered by ______________________ Insurance Co. and I assign directly to Dr. ______________ all insurance benefits otherwise payable to me. I understand that I am responsible for payment of all services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions, whether manual or electronic.

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Signature Date