



MEDICAL HISTORY *continued*

Your current physical health is: Good Fair Poor

Are you taking any prescription / over-the-counter or supplemental drugs? Yes No

Please list each one: _____

Do you smoke or use tobacco in any other form? Yes No

Have you ever taken Fosamax, or any other bisphosphonate? Yes No

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? Yes No

For Women: Are you using a prescribed method of birth control? Yes No

Are you pregnant? Yes No Week #: _____

Are you nursing? Yes No

Have you ever had any of the following disease or medical problems? (Please circle option that applies)

- | | |
|---|------------------------------------|
| Y N Anemia / Radiation Treatment | Y N Hemophilia / Abnormal Bleeding |
| Y N Artificial Bones / Joints / Valves | Y N Hepatitis |
| Y N Arthritis | Y N High / Low Blood Pressure |
| Y N Asthma | Y N HIV+ / AIDS |
| Y N Blood Transfusion | Y N Hospitalized for Any Reason |
| Y N Cancer / Chemotherapy | Y N Kidney Problems |
| Y N Congenital Heart Defect | Y N Mitral Valve Prolapse |
| Y N Diabetes | Y N Psychiatric Treatment |
| Y N Difficulty Breathing | Y N Rheumatic / Scarlet Fever |
| Y N Drug / Alcohol Abuse | Y N Severe / Frequent Headaches |
| Y N Emphysema / Glaucoma | Y N Shingles |
| Y N Epilepsy / Seizures / Fainting Spells | Y N Sickle Cell Disease / Traits |
| Y N Fever Blisters / Herpes | Y N Sinus Problems |
| Y N Heart Attack / Stroke | Y N Tuberculosis (TB) |
| Y N Heart Murmur | Y N Ulcers / Colitis |
| Y N Heart Surgery / Pacemaker | Y N Venereal Disease |

Please list any serious medical condition(s) that you have ever had: _____

Are you allergic to any of the following?

- | | | |
|------------------------|----------------------|------------------|
| Y N Aspirin | Y N Erythromycin | Y N Penicillin |
| Y N Codeine | Y N Jewelry / Metals | Y N Tetracycline |
| Y N Dental Anesthetics | Y N Latex | Y N Other |

Please list any other drugs / materials that you are allergic to: _____



DENTAL HISTORY

Why have you come to the dentist today?

Do you require antibiotics before dental treatment? Yes No

Are you currently in pain? Yes No

Have you ever had a serious / difficult problem associated with any previous dental work? Yes No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? Yes No

Your current dental health is: Good Fair Poor

Do you like your smile? Yes No

Do your gums ever bleed? Yes No

Have you ever had periodontal disease? Yes No

How many times a week do you floss? _____ a day do you brush? _____

Type of bristles? Hard Medium Soft



I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information 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 any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature _____

Date _____

Payment is due in full at the time of treatment unless prior arrangements have been approved.



Thank you for filling out this form completely. It will enable us to help you more effectively. If you have questions at any time, please ask us. We are happy to help.

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

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials: _____ Date: _____

Doctor's Comments: _____

MEDICAL HISTORY UPDATE

1. Date: _____ Comments: _____ Signature: _____

1. Date: _____ Comments: _____ Signature: _____

1. Date: _____ Comments: _____ Signature: _____

WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum

oral health. Please fill out this form completely. The better we communicate, the better we can care for you. ☺

1 ABOUT YOU

Today's Date: _____
E-mail Address: _____
Name: _____
LAST FIRST MI MR MRS MS DR
I prefer to be called: _____ Male Female
Birthdate: ___/___/___ Age: ___ SS #: _____
Home Address: _____
CITY STATE ZIP
 Single Married Divorced Widowed Separated
Hm #: (____) _____ Pager / Cell #: _____
Wk #: (____) _____ Ext: _____ DL #: _____
Employer: _____
Employer's Address: _____
How long there? _____ Occupation: _____
Where & when are best times to reach you? _____
Whom may we Thank for referring you? _____
Other family members seen by us: _____
Previous / Present Dentist: _____
(Please Circle)
Last Visit Date: _____

3 DENTAL INSURANCE

Primary Dental Insurance

Insurance Co. Name: _____
Insurance Co. Address: _____
Insurance Co. Phone #: (____) _____
Group # (Plan, Local or Policy #): _____
Insured's Name: _____ Relation: _____
Insured's Birthdate: ___/___/___ Insured's ID #: _____
Insured's Employer: _____
Employer's Address: _____

Secondary Dental Insurance

Insurance Co. Name: _____
Insurance Co. Address: _____
Insurance Co. Phone #: (____) _____
Group # (Plan, Local or Policy #): _____
Insured's Name: _____ Relation: _____
Insured's Birthdate: ___/___/___ Insured's ID #: _____
Insured's Employer: _____
Employer's Address: _____

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her Name: _____ Relation: _____
Wk #: (____) _____ Hm #: (____) _____

2 SPOUSE INFORMATION

His / Her Name: _____
Employer: _____
Contact #: (____) _____ Ext: _____ SS #: _____
Birthdate: ___/___/___ DL #: _____

Person Responsible for Account: _____
Contact #: (____) _____
Billing Address: _____
Relation: _____ SS #: _____
Employer: _____ DL #: _____

4 MEDICAL HISTORY

Do you have a personal physician? Yes No

Physician's Name: _____
Wk #: (____) _____ Date of last visit? _____
Are you under the care of a physician? Yes No
Please explain: _____

CONTINUED ON BACK