Patient Medical/Dental History Form

***NAME:*________________________________** ***DATE:*__________________**

MEDICAL HISTORY

Please Circle Appropriate Response:

NO YES **Are you in good general health?**
NO YES Are you now taking any drugs or medications?
Which ones?____
____
____

NO YES Are you allergic to any medications?
Which ones? ____
____
____

Family Doctor:____
Phone:____
____

NO YES Would you object to our office contacting your family doctor in regard to any medical problem that may arise?
____

NO YES Have you ever received local anesthesia (Novocaine or Xylocaine) by a dentist or doctor?
NO YES Have you ever received general anesthesia?
NO YES Have you ever had any adverse reaction to either local or general anesthesia?
Please describe__________________________
NO YES Do you take blood thinners?
Which ones? ___________________________
NO YES Do you take vitamins regularly?
Which ones?____________________________
NO YES Do you take vitamins containing Vitamin E?
NO YES Do you take aspirin products or anti-inflammatory medicines or headache medicines?
Which ones?____________________________
NO YES Do you exercise regularly?

PLEASE LIST ALL PREVIOUS SURGERIES AND DATES:
____
____

DO ANY FAMILY MEMBERS HAVE: (Circle if yes)

Heart trouble	Tuberculosis
Excessive scarring	Excessive bleeding tendency
Diabetes	Psychiatric or “nerve” problems
Adverse reactions to anesthesia	

HAVE YOU HAD:

NO YES Blood pressure or related problems
NO YES Liver, gallbladder, problems
NO YES “yellow Jaundice”, Hepatitis problems
NO YES Heart trouble
NO YES Kidney disease
NO YES Diabetes
NO YES Stomach problems, indigestion or ulcers
NO YES Bleeding tendency or excessive bruising
NO YES Any part of your body paralyzed or numb
NO YES Psychiatric consultation
NO YES Epilepsy-convulsions or seizures
NO YES Broken bones of the face, neck, jaw or back
NO YES Back trouble
NO YES Abnormal chest x-rays
NO YES Abnormal Electrocardiogram (ECG)
NO YES Asthma or other respiratory problems
NO YES Any medical treatment for nervous condition
NO YES Excessive scarring
NO YES Tuberculosis
NO YES Thyroid problems
NO YES Any other illnesses. If so please list:
NO YES A gain or loss of more than 15 pounds in your body weight.
NO YES Abdominal or inguinal hemia
NO YES History of blood clots in legs or lungs
NO YES History of legs swelling
NO YES Glaucoma, cataracts
NO YES Dry eyes
NO YES Herpes or Cold Sores
Other:____

DO YOU:

NO YES Wear contact lenses
NO YES Have dentures, false teeth, caps or bridges
NO YES Smoke? How much? ____________________
NO YES Drink alcohol? How much? ______________
NO YES Think you are pregnant? Date of last menstrual period________________________
NO YES Have any contagious or infectious condition
NO YES Have you been exposed directly or indirectly to any one with HIV (AIDS)

The above information is strictly confidential

____
Patient Signature Date

____
Witness Signature Date

Patient Medical/Dental History Form

PATIENT DENTAL HISTORY

What is your reason for seeking care at this time: ____
Do you have regular dental checkups? When was your last dental exam: ______________________________
Have you had any dental x-rays completed within the last 5 years:_________________________________
Do you have any pain or discomfort now? What: ____
Do your gums bleed? _______________ Have you had surgery preformed on your gums? ____________
Have you ever had a root canal? _______ Have you ever worn braces? ______ Do you wear Dentures?_____
Do you grind your teeth?_______ Have you ever had any trauma to your face or mouth? _____________
Do you floss? How often ________ How many times a day do you brush your teeth? _______________

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

I also understand that I am responsible for any account balance and payment in full is expected at time of service, unless prior arrangements have been made. As a courtesy to our patients, your insurance claims will be completed for you. However, Insurance is between you and your insurance company. You are still responsible for any unpaid or denied claims.

All information is HIPPA compliant and will only be disclosed for medical or dental treatment.

______________________________________ Date: ______________________________
Signature of Patient/Parent or Guardian