

# Welcome

## Patient Medical and Dental History

To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

### Patient Information ( Confidential)

Referred by \_\_\_\_\_

Email \_\_\_\_\_

Name \_\_\_\_\_ Date \_\_\_\_\_

Soc. Sec# \_\_\_\_\_ Birthday \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Check Appropriate Box       Single       Married       Divorced       Widowed

Patient's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Person to contact in case of emergency \_\_\_\_\_

### Insurance Information

Name of insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_ Guarantor Birthday \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_ Guarantor S.S.# \_\_\_\_\_

### Medical Information

1) Physician \_\_\_\_\_ Office phone \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

2) Are you under medical treatment now? \_\_\_\_\_

If yes, please explain \_\_\_\_\_

3) Are you taking any medications, prescriptions or non-prescriptions? \_\_\_\_\_

If yes, please explain \_\_\_\_\_

4) Are you allergic to or have had any reaction to any medication or substance? \_\_\_\_\_

5) Do you smoke or use smokeless tobacco? \_\_\_\_\_

6) Women: Are you Pregnant? Yes, \_\_\_\_\_ months       No

Nursing?       Yes       No

7) Do you have or have you had any disease, conditions, or problems not listed?

If yes, please explain \_\_\_\_\_

8) Do you have or have you had any of the following? Please check the "Yes" or "No" box.

	Yes	No		Yes	No		Yes	No
Heart (surgery, disease, attack)	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Tumors	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis / Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	Neurological Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis / Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Joints (hip, knee, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Fainting or Dizzy Spells	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Trouble / Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Diet (special / restricted)	<input type="checkbox"/>	<input type="checkbox"/>	Nervous / Anxious	<input type="checkbox"/>	<input type="checkbox"/>
Latex Sensitivity	<input type="checkbox"/>	<input type="checkbox"/>	AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric/Psychological Care	<input type="checkbox"/>	<input type="checkbox"/>

**Dental Information**

- 1.) Whom may we thank for referring you? \_\_\_\_\_
- 2.) What is the reason for your visit today? \_\_\_\_\_  
\_\_\_\_\_
- 3.) What are your present dental problems? \_\_\_\_\_  
\_\_\_\_\_
- 4.) Date of last dental visit \_\_\_\_\_ Last dental cleaning \_\_\_\_\_ Last dental X-ray \_\_\_\_\_
- 5.) Do you have any sores or lumps in or near your mouth? \_\_\_\_\_  
If yes, please explain \_\_\_\_\_
- 6.) Have you had any head, neck or jaw injuries? \_\_\_\_\_  
If yes, please explain \_\_\_\_\_
- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 7.) Do you clench or grind your teeth?                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8.) Do you bite your lips or cheeks frequently?                          | <input type="checkbox"/> | <input type="checkbox"/> |
| 9.) Have you ever experienced any of the following problems in your jaw? |                          |                          |
| • Clicking or Popping  | <input type="checkbox"/> | <input type="checkbox"/> |
| • Difficulty in opening or closing                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| • Pain (joint, ears, or side of face)                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| 10.) Do your gums bleed while brushing or flossing?                      | <input type="checkbox"/> | <input type="checkbox"/> |
| 11.) Are your teeth sensitive to hot or cold liquids or foods?           | <input type="checkbox"/> | <input type="checkbox"/> |
| 12.) Are your teeth sensitive to sweet or sour liquids or foods?         | <input type="checkbox"/> | <input type="checkbox"/> |
| 13.) Do you have any pain in any teeth?                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| 14.) Have you noticed any mouth odors or bad tastes?                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 15.) Have you noticed any loose teeth or changes in your bite?           | <input type="checkbox"/> | <input type="checkbox"/> |
| 16.) Have you ever had oral surgery?                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 17.) Have you ever had periodontal treatment?                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 18.) Are you satisfied with your teeth's appearance?                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 19.) Do you feel nervous about having dental treatment?                  | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, what is your biggest concern? _____                              |                          |                          |

*I understand the above information is necessary to provide dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the receptive health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.*

Patient/ Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**History review**