PATIENT MEDICAL HISTORY

Patient's Name: _____ Birthday: _____
Address: _____
City: _____ State: _____ Zip: _____
Email: _____ Marital Status: _____ SSN: _____-_____-_____
Home PH: _____ Work PH: _____ CELL: _____

Dental Insurance Information: **(If this information is missing/incomplete we may not be able to bill)**
Primary Dental Policy Holder: _____ Date of birth: _____
Ins. Co._____ PH._____ Member ID: _____
Group #: _____ SSN _____ Employer _____
Secondary Dental Policy Holder: _____ Ins. Co. _____
PH: _____ Member ID: _____ Group # _____
Spouse_____ Employer_____

Medical Information:
Physician Name: _____ Physician Phone: _____
Pharmacy: _____ Pharmacy Phone: _____

Sex: Male ☐ Female ☐

If female, please answer by circling the following:

Y ☐ N ☐ Are you taking birth control pills?

Y ☐ N ☐ Are you pregnant? If yes # of wks: _____

Y ☐ N ☐ Are you nursing?

Please answer the following:

Y ☐ N ☐ Do you smoke or use tobacco?

Y ☐ N ☐ Do you have a history of substance abuse?

Height: _____ Weight: _____

Y ☐ N ☐ Have you ever had a sleep test or CPAP?

CONDITIONS: PLEASE CIRCLE ALL THAT APPLY TO YOU

Yellow Jaundice
Venereal Disease
Ulcers
Tuberculosis
Thyroid Problems
Stroke
Sinus Problems
Sickle Cell Disease
Shingles
Seizers
Rheumatic Fever
Radiation Therapy
Psychiatric Problems
Pace Maker
Mitral Valve Prolepses
Liver Disease
Kidney Problems
HIV-AIDS
High Blood Pressure
Hepatitis A B or C (circle)
Hemophilia

Heart Surgery
Heart Attack
Glaucoma
Frequent Headaches
Fever Blisters
Fainting Spells
Epilepsy
Emphysema
Sleep Apnea
Difficulty Breathing
Diabetes
Cosmetic Surgery
Congenital Heart Defect
Colitis
Cancer-Chemotherapy
Blood Transfusion
Asthma
Artificial Heart Valve
Artificial Bones
Arthritis
Angina Pectoris

Anemia
Allergies
Pain in Jaw Joints
Abnormal bleeding
Hay Fever
Low Blood Pressure
Alcohol Abuse
Drug Abuse

Allergies
Aspirin
Codeine
Dental Anesthetics
Erythromycin
Jewelry
Latex
Metals
Penicillin
Tetracycline
Other

OVER →

List ALL medications:

Is there any disease, condition or problem that you think this office should know about that is **NOT** covered on the list on the front page? If yes, please describe below: Y ☐ N ☐

Dental Questions:

What would you like us to do today? _____

Are you in dental discomfort today? Y ☐ N ☐ If yes, what is your pain level on a scale of 1-10? _____

How did you hear about our office? _____

Former Dentist: _____ Dentist's Email: _____

Address: _____ PH: _____

Date of last exam: _____ Date of last x-rays: _____

Y N Conditions

☐ ☐ Bad Breath

☐ ☐ Grinding/ clenching teeth

☐ ☐ Loose teeth/ broken fillings

☐ ☐ Sensitivity when biting

☐ ☐ Clicking / popping jaw

☐ ☐ Sensitivity to hot or cold

Y N Conditions

☐ ☐ Periodontal Treatment

☐ ☐ Sensitivity to cold

☐ ☐ Bleeding gums

☐ ☐ Sensitivity to sweets

☐ ☐ Sores or growths in mouth

☐ ☐ Food collection between teeth

How often do you brush? _____ How often do you floss? _____

How do you feel about your appearance of your teeth? _____

Have you ever experienced an adverse reaction during/after with a medical or dental procedure? Y ☐ N ☐

Have you ever had or are you interested in facial aesthetics (botox/fillers/skin-care)? Y ☐ N ☐

Would you like a tour of our office today? Y ☐ N ☐

ADDITIONAL NOTES:

By signing this form I acknowledge I have answered the questions on both sides of this form honestly & to the best of my ability.

Signature:_____**Date:**_____

(if under 18, Parent or Guardian Signature required)