Dental & Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health Problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

If you answer yes to any of the following, please explain in the blank provide to the right. Thank you.

Are you having a dental problem at this time?	O No	O Yes, Please List:	
Are your teeth sensitive to hot, cold or biting pressure?	O No	O Yes	
Do you floss regular?	O No	O Yes	
Are you under a physician's care now?	O No	O Yes, Please List:	
Have you ever been hospitalized or had a major operation?	O No	O Yes, Please List:	
Have you ever had a serious head or neck injury?	O No	O Yes, Please List:	
Are you taking any medications, pills or drugs?	O No	O Yes, Please List:	
Do you take, have you taken Phen-Fen or Redux?	O No	O Yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	O No	O Yes	
Are you on a special diet?	O No	O Yes, Please List:	
Do you use tobacco?	O No	O Yes, Please List:	Amount per day?
Do you use controlled substances?	O No	O Yes, Please List:	

Women: Are you
Pregnant/Trying to get pregnant? O Yes O No Taking oral Contraceptives? O Yes O No Nursing? O Yes O No

Are you allergic to any of the following?
O Aspirin O Penicillin O Codeine O Local Anesthetics O Acrylic O Metal O Latex O Sulfa Drugs

O Other If yes, please explain:

Please mark all that you have had or have now:

O AIDS/HIV	O Cortisone Medicine	O Heart Trouble/Disease	O Periodontal Surgery
O Alzheimer's	O Crown/Bridge	O Hemophilia	O Psychiatric Care
O Anaphylaxis	O Dental Implants	O Hepatitis A	O Radiation Treatments
O Anemia	O Dentures	O Hepatitis B or C	O Recent Weight Loss
O Angina	O Diabetes	O Herpes	O Renal Dialysis
O Arthritis/Gout	O Drug Addiction	O High Blood Pressure	O Retainer
O Artificial Heart Valve	O Easily Winded	O High Cholesterol	O Rheumatic Fever
O Artificial Joint	O Emphysema	O Hives or Rash	O Rheumatism
O Asthma	O Epilepsy or Seizures	O Hypoglycemia	O Scarlet Fever
O Blood Disease	O Excessive Bleeding	O Irregular Heartbeat	O Shingles
O Blood Transfusion	O Excessive Thirst	O Jaw Pain/Popping/Clicking	O Sickle Cell Disease
O Breathing Problems	O Fainting Spells/Dizziness	O Kidney Problems	O Sinus Trouble
O Bruise Easily	O Frequent Cough	O Leukemia	O Spina Bifida
O Bleaching	O Frequent Diarrhea	O Liver Disease	O Stomach/Intestinal Disease
O Bleeding Gums	O Frequent Headaches	O Low Blood Pressure	O Stroke
O Bonding/Veneers	O Genital Herpes	O Lung Disease	O Swelling of Limbs
O Cancer	O Glaucoma	O Mitral Valve Prolapse	O Thyroid Disease
O Chemotherapy	O Gum Disease	O Night Guard	O TMJ
O Chest Pains	O Hay Fever	O Orthodontics	O Tonsillitis
O Cold Sores/Fever Blisters	O Heart Attack/Failure	O Osteoporosis	O Tuberculosis
O Congenital Heart Disorder	O Heart Murmur	O Parathyroid Disease	O Tumor or Growths
O Convulsions	O Heart Pacemaker	O Periodontal Scaling	O Ulcers
			O Venereal Disease
			O Yellow Jaundice

Have you ever had any serious illness not listed above? O Yes O No
If yes, please explain:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. **It is my responsibility to inform the dental office of any changes in medical status and/or medications taken.**

Signature of Patient, Parent or Guardian Date

Patient Registration

How did you hear about our office? ☐ Referred By: _____ ☐ Phone Book

☐ Website / Online Search ☐ News Paper ☐ Other: _____

Date:_____

Patient Information:

First Name:_____ Last Name:_____

Middle Initial:_____ Preferred Name / Nick Name:_____ Sex: ☐ Male ☐ Female

Address:_____ City:_____ ST:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Birth Date:_____ Social Security #:_____ Drivers License:_____

E-Mail Address:_____ ☐ I would like to receive information via e-mail.

When confirming appointments and for check-up reminders, the best place to reach me is:

☐ Home ☐ Work ☐ Cellular ☐ E-mail ☐ Other:_____

Responsible Party: (If someone other than patient)

First Name:_____ Last Name:_____ Middle Initial:_____

Address:_____ City:_____ ST:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Birth Date:_____ Social Security #:_____ Drivers License:_____

E-Mail Address:_____ ☐ I would like to receive information via e-mail.

If you need to contact me in regards to this account, the best place to reach me is:

☐ Home ☐ Work ☐ Cellular ☐ Other:_____

Payment Information: (Please check one)

☐ I am self pay **OR** ☐ I have provided insurance information

Emergency Contact Information:

Name:_____ Relationship to Patient:_____ Phone #:_____

Name:_____ Relationship to Patient:_____ Phone #:_____