



Medical & Dental History Form

Patient Name:
Last First MI Preferred Name

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Within the past year, have there been any changes in your general health?

Yes No

Your Primary Care Physician's name, address, & phone number:

Please mark any of the following to indicate Yes in response to the question:

- Have you ever had complications following dental treatment?
- Are you currently under the care of a physician due to a specific condition?
- Are you currently taking any prescription or non-prescription medications?
- Do you use tobacco (smoking or chewing)?
- Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

If any of the previous questions are marked, please explain:



WOMEN ONLY: Are you pregnant?

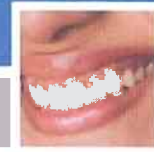
Yes No

If Yes, when is the due date?

Please indicate if you have experienced any of the following:

- | | | |
|---|---|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Codeine Allergy | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Excessive Bleeding |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Growths |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> HIV | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Nervous Disorders |
| <input type="checkbox"/> Other | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Pre-Medicate | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Rheumatism |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tumors | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Venereal Disease | | |

Do you have any other health issues or allergies?



When was your last visit to the dentist (if to a different office)?

Prior Dentist's name, address, & phone number:

Please mark any of the following to indicate Yes in response to the question:

- Do your gums bleed when you brush or floss?
- Do your teeth experience sensitivity to cold or hot temperatures?
- Are any of your teeth currently causing you pain?
- Do you grind your teeth (either consciously or during sleep)?
- Are any of your teeth loose, or are you concerned about any teeth loosening?
- Do you currently have any dental implants, dentures, or partials?

If any of the previous questions are marked, please explain:



If you could change anything about your mouth, teeth, or smile, what would it be?

To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian:

Signature: _____

Date:

Relationship to Patient:

Response Date: