



Welcome! So that we may provide you with the best possible care please complete both sides of this dental/medical history form. All information is completely confidential. Thank You.

What is the reason for your visit today? _____

Name _____ Date of Birth _____

Address _____ Social Security Number _____

Home Phone _____ Alternate Phone _____

Email _____

Dentist _____ Town _____

Physician _____ Town _____ Last Physical Exam _____

Occupation/Job Title _____

DENTAL INSURANCE

Insurance Carrier _____ Address _____

Policy Holder _____ Group No. _____

Social Security Number _____ Date of Birth _____

Employer _____ Employer Address _____

DENTAL HEALTH

What do you do at home to take care of your teeth? _____

Is there anything you would like to change about your teeth? _____

Did you or do you happen to smoke or use any form of tobacco? Yes No

If so, how much and for how many years? _____

Do you have a family history of gum disease or early tooth loss? (Grandparents, parents, or siblings) Yes No

Have you ever had:

Braces? Yes No
Gum/Periodontal Treatment? Yes No
Oral Surgery? Yes No
Bite plate, mouth guard or Night Guard? Yes No
Trauma or Injury to the mouth or head? Yes No

Do you:

Clench or grind your teeth? Yes No
Nail biting habit? Yes No
Aggressive Brushing Habit? Yes No
Joint Pain in your Jaw? Yes No
Muscle Pain in your Jaw? Yes No

Are any of your teeth sensitive to: (Circle all that apply)

Hot Cold Sweets Biting or Chewing

Do you frequently get cold sores, blisters, or any other oral lesions? Yes No

Are you currently experiencing any dental pain? Yes No

Is there anything else you would like us to know regarding your past dental treatment? Yes No

If so, please describe _____

MEDICAL HEALTH

1. Have you been under the care of a medical doctor during the past 2 years? Yes No
2. Have you been hospitalized or had surgery in the past 5 years? Yes No
If so, please list date and why _____
3. Are you taking any medications, or supplements? (including anything over-the-counter)..... Yes No
If so, please list: _____

4. Are you allergic to anything? (medications, materials, or food) Yes No
If so, please list: _____

5. Have you ever taken any medication for Osteoporosis? Ex. Bisphosphonate drugs, Fosamax, Prolia, Boniva Yes No
6. Do you have any artificial joints? Yes No
If so, please list joint and date of surgery: _____
7. Does your Physician require you to premedicate with antibiotics before dental treatment? Yes No
If so, please list antibiotic and dosage: _____
8. Have you lost or gained more than 10 pounds in the past year?..... Yes No
9. Indicate which of the following pertain to you:

| | | | | | | | | |
|--|-----|----|-------------------------|-----|----|--|-----|----|
| Heart (Surgery, Disease, Attack)..... | Yes | No | Ulcers..... | Yes | No | Hepatitis A (infectious), B (serum)..... | Yes | No |
| Chest Pain..... | Yes | No | Diabetes..... | Yes | No | Venereal Disease..... | Yes | No |
| Congenital Heart Disease..... | Yes | No | Thyroid Problem..... | Yes | No | A.I.D.S..... | Yes | No |
| Heart Murmur..... | Yes | No | Glaucoma..... | Yes | No | H.I.V. Positive..... | Yes | No |
| High Blood Pressure..... | Yes | No | Contact Lenses..... | Yes | No | Cold Sores/Fever Blisters..... | Yes | No |
| Mitral Valve Prolapse..... | Yes | No | Emphysema..... | Yes | No | Blood Transfusion..... | Yes | No |
| Artificial Heart Valve..... | Yes | No | Chronic Cough..... | Yes | No | Hemophilia..... | Yes | No |
| Heart Pacemaker..... | Yes | No | Tuberculosis..... | Yes | No | Sickle Cell Disease..... | Yes | No |
| Rheumatic Fever..... | Yes | No | Asthma..... | Yes | No | Bruise Easily..... | Yes | No |
| Arthritis/Pneumatism..... | Yes | No | Hay Fever..... | Yes | No | Liver Disease..... | Yes | No |
| Swollen Ankles..... | Yes | No | Latex Sensitivity..... | Yes | No | Yellow Jaundice..... | Yes | No |
| Stroke..... | Yes | No | Allergies or Hives..... | Yes | No | Neurological Disorders..... | Yes | No |
| Diet (Special/Pestricted)..... | Yes | No | Sinus Trouble..... | Yes | No | Epilepsy or Seizures..... | Yes | No |
| Artificial Joints (hip, knee, etc.)..... | Yes | No | Radiation Therapy..... | Yes | No | Fainting or Dizzy Spells..... | Yes | No |
| Kidney Trouble..... | Yes | No | Chemotherapy..... | Yes | No | Nervous/Anxious..... | Yes | No |
| Cancer..... | Yes | No | Tumors..... | Yes | No | Psychiatric/Psychological Care..... | Yes | No |
10. Do you have or have you had any disease, condition or problem not listed?..... Yes No
If so, please list _____
11. **Women:** Are You: **Pregnant?** Yes, ___ Months No **Nursing?** Yes No **Taking birth control pills?** Yes No

I understand the above information is necessary in order to provide me with dental care in a safe and efficient manner. I understand that withholding information about my medical history can have serious negative consequences to my health and well-being. I have answered all questions to be best of my knowledge. Should further information be needed, you have my permission to ask the appropriate health care provider or agency who may release such information to you. I will notify the doctor of any change in my health or medications.

Patient/Guardian Signature _____ Date _____