PATIENT MEDICAL HISTORY

Name of Physician _____ Phone # _____

Are you currently under the care of a physician? _____ if yes explain? _____

_____

Have you undergone any surgeries? _____ if so, what _____

_____

WOMEN are you pregnant or trying to become pregnant? _____ if yes what trimester are you in? _____

Are you taking any medication? _____ if so, what _____

Are you allergic to any medications? _____ if so, what _____

Are you allergic to latex rubber, metals, iodine, or anything other? _____

Have you had any adverse reactions to medications? _____ if so, what _____

Is there anything else we should know about your medical history? _____

_____

Please place a check mark next to all that apply to you, the patient. (a check mark means yes)

☐ Heart Disease	☐ Hemophilia	☐ Psychiatric Care	☐ Hepatitis A, B, or C
☐ Heart Murmur	☐ Respiratory Disease	☐ Depression	☐ Jaundice
☐ Mitrovalve Prolapse	☐ Asthma	☐ ADHD or ADD	☐ Recent Weight Loss
☐ Artificial Heart Valves	☐ Tobacco Usage	☐ Diabetes	☐ Special Diet
☐ Heart Attack	☐ Kidney Disease	☐ Chronic Diarrhea	☐ Chemical Dependency
☐ Stroke	☐ Liver Disease	☐ Arthritis	☐ Allergies to Anesthetics
☐ Heart Surgery	☐ Blood Disease	☐ Artificial Joints	☐ General Allergies
☐ Cardiac Pacemaker	☐ Cancer	☐ Implants	☐ Anemia
☐ Rheumatic Fever	☐ Leukemia	☐ Back Problems	☐ Fainting/Seizures
☐ Scarlet Fever	☐ Radiation Treatment	☐ Sinus Problems	☐ Epilepsy/Convulsions
☐ High Blood Pressure	☐ Epilepsy	☐ Swollen Neck Glands	☐ Emphysema
☐ Low Blood Pressure	☐ Headaches	☐ Ulcers	
☐ Circulatory Problems	☐ Nervous Problems	☐ Aids or HIV	

Dental History

Name of previous dentist _____ Date of last exam _____

Do you require pre-medication for dental treatment? _____

Do your gums bleed while brushing or flossing _____

Are your teeth sensitive to hot or cold liquids/foods? _____

Are your teeth sensitive to sweet or sour liquids/foods? _____

Do you feel pain in any of your teeth? _____

Do you have any sores or lumps in or near your mouth? _____

Have you had any head, neck, or jaw injuries? _____

Do you have frequent headaches? _____

Do you clench or grind your teeth? _____

Do you bite lips or cheeks frequently? _____

Have you had any orthodontic treatment? _____

Do you wear dentures or partials? _____

Have you ever had any difficult extractions in the past? _____

Have you ever had any prolonged bleeding following extractions? _____

Have you ever experienced any of the following problems in your jaw? _____

- ☐ Clicking
- ☐ Pain (joint, ear, side of face)
- ☐ Difficulty in opening or closing jaw
- ☐ Difficulty in chewing

AUTHORIZATION AND RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Clear Form

_____

Signature of patient (or parent if minor)

Doctor's Comments _____

_____

_____ Signature _____ Date _____