Curtis E. Hahn, D.D.S.
4992 Wilson Avenue | Grandville, MI 49418
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Rivertown Dental Associates

Medical and Dental Health History Form

Patient Name Last _____ First _____ Middle Initial _____

Date of birth: _____

Would you consider yourself to be in fairly good health? ☐ Yes ☐ No

Within the past year, have there been any changes in your general health? ☐ Yes ☐ No

Have you been hospitalized within the last 5 years due to an illness, injury or other condition? ☐ Yes ☐ No
If yes, please explain:

_____

_____

What is the date (or approximate date) of your last medical exam? _____

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

_____

_____

Preferred pharmacy location and phone number

_____

Are you currently taking any prescription or non-prescription medications
(including vitamins, supplements or natural products / remedies)? ☐ Yes ☐ No

Please list any medications you are currently taking, one medication per line:

_____ _____

_____ _____

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

☐ Have your ever been dependent on drugs or alcohol? Are you on a salt restricted diet?
☐ Has your physician ever recommended taking antibiotics prior to dental appointments?
☐ Have you ever had complications following dental treatment?
☐ Do you smoke or use other forms tobacco or marijuana?
☐ Do you require the use of corrective lenses (contacts or glasses)?
☐ Do you have difficulty hearing or require the use of hearing aids?
☐ 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:

_____

_____

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Please indicate if you have experienced any of the following (please check all that apply.

☐ Acid Reflux	☐ AIDS	☐ Allergy: Fluoride	☐ Allergy: Ibuprofen
☐ Allergy: Latex	☐ Allergy: Amoxicillin	☐ Allergy: Anesthetic	☐ Allergy: Aspirin
☐ Allergy: Codeine	☐ Allergy: Erthromycin	☐ Allergy: Foods	☐ Allergy: Iodine
☐ Allergy: Latex	☐ Allergy: Metals	☐ Allergy: Penicillin	☐ Allergy: Sulfa Drugs
☐ Allergy: Vicodin	☐ Anemia	☐ Angina	☐ Anorexia/Bulimia
☐ Anxiety	☐ Arthritis	☐ Artif. Heart Valve	☐ Artificial Joints
☐ Asthma	☐ Avoid NSAID Drugs	☐ Bisphosphonate Rx	☐ Cancer
☐ Cold Sores	☐ Congen Heart Disease	☐ Cosmetic Surgery	☐ Depression
☐ Diabetes	☐ Difficulty Sleeping	☐ Dizziness	☐ Emphysema
☐ Epilepsy	☐ Fainting	☐ GERD	☐ glacoma
☐ Hay Fever	☐ Head Injuries	☐ Headaches	☐ Heart Attack
☐ Heart Disease	☐ Heart Murmur	☐ Heart Surgery	☐ Hemophilia
☐ Hepatitis	☐ HIV	☐ Hypertension-High BP	☐ Jaw Injury
☐ Jaw Joint Pain	☐ Kidney Disease	☐ Laryngospasm	☐ Liver Disease
☐ Mitral Valve Prolap	☐ Multiple Allergies	☐ Nervous Disorders	☐ Pacemaker
☐ Pre-Med	☐ Psychiatric Treatmnt	☐ Radiation Treatment	☐ Rheumatic Fever
☐ Seizures	☐ Sinus Problems	☐ Sleep Apnea	☐ Snoring
☐ Stroke	☐ Thyroid Disease	☐ Tuberculosis (TB)	☐ Tumor
☐ Ulcer			

Do you have any other health issues or allergies that need further clarification? ☐ Yes ☐ No
If yes, please explain:

_____

_____

[WOMEN ONLY] Are you taking birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

If yes, when is the due date? _____

How frequently do you brush your teeth?

☐ 3(+) a day ☐ Twice a day ☐ Once a day ☐ Weekly ☐ Seldom

How frequently do you floss your teeth?

☐ 1(+) a day ☐ 2-6 weekly ☐ 1-6 monthly ☐ Seldom ☐ Never

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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:

_____

_____

☐ 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).

_____ Date: _____ Relationship to Patient: _____

(Signature of patient, parent, or legal guardian)