



Medical and Dental Health History Form

Patient Name Last _____ First _____ Middle Initial _____
Date of birth: _____ Cell # _____ Email _____

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:

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

Are you pregnant? Yes No

If yes, when is the due date? _____

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

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Acid Reflux/GERD | <input type="checkbox"/> AIDS | <input type="checkbox"/> Allergy: Erythromycin | <input type="checkbox"/> Allergy: Latex |
| <input type="checkbox"/> Allergy: Metals | <input type="checkbox"/> Allergy: Penicillin | <input type="checkbox"/> Allergy: Sulfa Drugs | <input type="checkbox"/> Allergy: Other |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Anemia | <input type="checkbox"/> Angina | <input type="checkbox"/> Anorexia/Bulimia |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Avoid NSAID Drugs | <input type="checkbox"/> Bisphosphonate Rx | <input type="checkbox"/> Cancer | <input type="checkbox"/> Cold Sores |
| <input type="checkbox"/> Cong. Heart Disease | <input type="checkbox"/> Cosmetic Surgery | <input type="checkbox"/> Depression | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Difficulty Sleeping | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Epilepsy/Seizures |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> HIV |
| <input type="checkbox"/> HPV/STD | <input type="checkbox"/> Hypertension-High BP | <input type="checkbox"/> Jaw Injury | <input type="checkbox"/> Jaw Joint Pain |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Laryngospasm | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Pre-Med | <input type="checkbox"/> Psychiatric Treatment |
| <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Seizures | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Snoring | <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Tuberculosis (TB) | <input type="checkbox"/> Tumor | <input type="checkbox"/> Ulcers | |

Additional details on positive answers above:

Do you have any other health issues or allergies that need further clarification?
If yes, please explain:

Yes No

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

- Have you 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, vape, 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:



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

What was the date of your last dental visit? _____

What is the name and location of your previous dentist? _____

Do you have dental anxiety?

- Yes No

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

- Are any of your teeth currently causing you pain?
- Have you ever been diagnosed with or been treated for gum/periodontal disease?
- Do your gums bleed when you brush or floss?
- Do your teeth experience sensitivity to cold or hot temperatures?
- 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?
- Do you have any dental appliances (retainers, bite guard)?
- Have you had orthodontic treatment in the past?

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).

(Signature of patient, parent, or legal guardian) Date: _____ Relationship to Patient: _____

Everyone deserves a healthy smile!