Medical and Dental History

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Physician/Clinic Name:

_____

_____

Are you currently under medical care? ○ Yes ○ No

Medical Alerts

- ☐ Acid Reflux
- ☐ Allergy Latex
- ☐ Anxiety/Depression
- ☐ Asthma
- ☐ Chemical Dependency
- ☐ Cong. Heart Problem
- ☐ Emphysema
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Mitral V. Prolapse
- ☐ Premed
- ☐ Shortness of Breath
- ☐ Swelling
- ☐ Tumors
- ☐ AIDS/HIV Infection
- ☐ Allergy Medication
- ☐ Art. Heart Valve
- ☐ Blood Disease
- ☐ Chemo/Radiation
- ☐ Controlled Substance
- ☐ Epilepsy/Seizures
- ☐ Hay Fever
- ☐ Heart Murmur
- ☐ High Cholesterol
- ☐ Kidney Trouble
- ☐ Neurologic Condition
- ☐ Respiratory Problems
- ☐ STD
- ☐ Thyroid Problem
- ☐ Allergies
- ☐ Allergy Metals
- ☐ Arthritis
- ☐ Blood Thinners
- ☐ Chest Pain
- ☐ Diabetes
- ☐ Fainting/Dizzy Spell
- ☐ Headaches/Migraines
- ☐ Heart Surgery
- ☐ Hives or Skin Rash
- ☐ Liver Disease
- ☐ No Epinephrine
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Tobacco Use
- ☐ Allergy Antibiotic
- ☐ Anemia
- ☐ Artificial Joints
- ☐ Cancer/Leukemia
- ☐ Cong. Heart Failure
- ☐ Eating Disorder
- ☐ Gastric Ulcers
- ☐ Heart Attack
- ☐ Hepatitis
- ☐ Hypoglycemia
- ☐ Mental Disorders
- ☐ Pacemaker
- ☐ See Pt Note
- ☐ Sudden Wt Gain/Loss
- ☐ Tuberculosis

Please list all current medications and supplements (prescription and over-the-counter):

_____

_____

_____

_____

_____

_____

_____

_____

_____

Within the last 5 years, have you been hosptilized for any surgical operation or illness? Please explain:

_____

_____

Have you ever had excessive bleeding requiring special treatment? Please explain:

_____

_____

Women Only:

Are you pregnant or do you think you may be pregnant? ○ Yes ○ No

Are you nursing? ○ Yes ○ No

Are you taking birth control pills? ○ Yes ○ No

Dental History

Previous Dentist:

_____

_____

Last Dental Visit: _____

Last Xrays Taken: _____

How often do you brush? _____

How often do you floss? _____

Do your gums bleed with brushing or flossing? ○ Yes ○ No

Do you have sensitive teeth? (Hot, Cold, Sweets) ○ Yes ○ No

Do you frequently get food caught between your teeth? ○ Yes ○ No

Do you have any dental problems at this time? ○ Yes ○ No

Do you clench or grind your teeth? ○ Yes ○ No

Do you wake with headaches, sore facial muscles or sore jaw joint? ○ Yes ○ No

Do you wear a guard to protect your teeth at night? ○ Yes ○ No

Do you have any lumps or sores in or near your mouth? ○ Yes ○ No

Have you ever had a bad experience in a dental office? ○ Yes ○ No

Have you ever had Botulinum Toxin or dermal filler facial treatments? ○ Yes ○ No

Do you snore, been told you snore, or have you been diagnosed with sleep apnea? ○ Yes ○ No

Have you ever had a sleep study performed? If yes, what were the results? _____

Have you had any head, neck or jaw injuries? ○ Yes ○ No

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

☐ Clicking ☐ Pain ☐ Difficulty opening or closing

☐ Difficulty chewing

Have you been examined for a TMD problem before or feel you have a TMD problem? ○ Yes ○ No

Do you feel you have symptoms or stress factors that cause head or neck pain? ○ Yes ○ No

Authorization and Release

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 use of radiographs, study models, photographs, or other diagnostic aids deemed appropriate to obtain a diagnosis. I authorize treatment. I authorize the use of my photographs for educational purposes.

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:
____/____/_____