MEDICAL AND DENTAL HISTORY

MEDICAL

Physician Name:____ Phone:____________________

Are you under the care of a physician now? ❐Yes ❐No If **yes**, please explain: ____________________

Do you currently have, or have you ever had any of the following:

Condition		Condition		Condition	
Heart Failure	❐Yes ❐No	Hepatitis	❐Yes ❐No	Nervousness/Depression	❐Yes ❐No
Heart Disease/Attack	❐Yes ❐No	Liver Disease	❐Yes ❐No	Psychiatric Treatment	❐Yes ❐No
Chest Pain	❐Yes ❐No	Epilepsy or Seizures	❐Yes ❐No	Multiple Sclerosis	❐Yes ❐No
High Blood Pressure	❐Yes ❐No	Fainting/Dizzy Spells	❐Yes ❐No	Diabetes	❐Yes ❐No
Heart Murmur	❐Yes ❐No	Cancer/Leukemia	❐Yes ❐No	Thyroid Disease	❐Yes ❐No
Mitral Valve Prolapse	❐Yes ❐No	Chemotherapy	❐Yes ❐No	HIV Positive	❐Yes ❐No
Rheumatic Fever	❐Yes ❐No	Glaucoma	❐Yes ❐No	AIDS	❐Yes ❐No
Heart Defects	❐Yes ❐No	Emphysema	❐Yes ❐No	Arthritis	❐Yes ❐No
Scarlet Fever	❐Yes ❐No	Asthma	❐Yes ❐No	Pain in Jaw Joints	❐Yes ❐No
Artificial Heart Valve	❐Yes ❐No	Difficulties Breathing	❐Yes ❐No	Loss of Appetite	❐Yes ❐No
Heart Pacemaker	❐Yes ❐No	SinusTrouble	❐Yes ❐No	Loss of Sleep	❐Yes ❐No
Heart Surgery	❐Yes ❐No	Severe Allergies/hives	❐Yes ❐No	Use a C-Pap	❐Yes ❐No
Artificial Joints/Prosthesis	❐Yes ❐No	Yellow Jaundice	❐Yes ❐No	Loud Snoring	❐Yes ❐No
Anemia	❐Yes ❐No	Drug Addiction	❐Yes ❐No	Bruise Easily	❐Yes ❐No
Stroke	❐Yes ❐No	Hemophilia	❐Yes ❐No	(Frequent) Cold Sores	❐Yes ❐No
Kidney Disease	❐Yes ❐No	Sickle Cell Disease	❐Yes ❐No	Adverse reaction to local anesthetic (Novocaine)	❐Yes ❐No

Are you **pregnant** or trying to get pregnant? ❐Yes ❐No **Are you currently taking Birth Control Pills?** ❐Yes ❐No

Are you currently taking Blood Thinners? ❐Yes ❐No **Do you have a LATEX allergy?** ❐Yes ❐No

Do you **smoke**? ❐Yes ❐No If yes, for how long have you been a smoker? ___________ How much do you smoke? __________

List any and all medications that you are currently taking: ____

____

List any and all medications that you are knowingly allergic to, or have had an adverse reaction to:____________________

____

Is there any other medical information not included above which you feel we should be informed about? ❐Yes ❐No

If YES, please explain: ____

Have you ever or do you currently receive Botox® Injections? ❐Yes ❐No

If YES, please indicate the nature of your treatment: ❐Therapeutic ❐Cosmetic ❐Both

DENTAL

Question		*(office use)*
Has the fear of discomfort kept you from regular dental visits?	❐Yes ❐No	
Are you satisfied with your past dentistry?	❐Yes ❐No	
Have you ever had a bad experience in a dental office?	❐Yes ❐No	
Are you concerned that you may have bad breath?	❐Yes ❐No	
Do your gums bleed easily,or feel tender and/or irritated?	❐Yes ❐No	
Are your teeth sensitive to hot, cold and/or sweets?	❐Yes ❐No	
Are there areas in your mouth where food sticks and/or gets caught?	❐Yes ❐No	
Are you self-conscious about the appearance of your teeth?	❐Yes ❐No	
Do your jaws often feel tired and/or sore?	❐Yes ❐No	
Do you experience excessive headaches and/or neck pain?	❐Yes ❐No	
Do you experience clicking/popping when opening/closing/chewing?	❐Yes ❐No	
Are you aware of yourself clenching or grinding your teeth?	❐Yes ❐No	
Have you ever had Orthodontic Treatment (Braces)?	❐Yes ❐No	

1. What prompted you to seek dental care at this time? ____
2. Approximately how long has it been since your last dental examination & cleaning? ____________________
3. **What, if anything, would you do to change the appearance of your teeth:** *(check all that apply)*

❐ Whiter ❐ Straighter ❐ Longer ❐ Shorter ❐ Shaped differently ❐ I would not change anything

CONSENT

I acknowledge that all of the above information is accurate to the best of my knowledge. I authorize this office and its trained staff to take x-rays & other diagnostic aids needed to make proper diagnosis of my dental needs. I authorize this office and its trained staff to perform all forms of treatment, as is indicated. I understand the use of anesthetic agents will be used when indicated & that this embodies a certain risk. I give my permission to release medical/dental information as needed to process insurance claim forms or to receive proper treatment from other health providers.

______________________________ ______________________________ ______________

Signature of Patient / Parent or Guardian Dr. Signature Date