Date:_____

Name:_____
(last) (first) (middle)

Address:_____
(street) (city) (zip)

Telephone/Home #:_____**WK#**_____

Cell #_____**"E" Mail address:**_____

Date of Birth_____**Sex:**___**Height:**_____**Weight:**____**Marital Status**_S_M_W_D
(circle one)

Occupation:_____**Social Security #**_____

Person Financially Responsible for the Account:_____

Dental Insurance Co. :_____**Employer:**_____
(if applicable)

Name of Policy Holder:_____**S.S.#**_____**Birth Date:**_____

Who can we thank for referring you?_____

Patient Name	**DENTAL HISTORY**
Patient Account No.	Medical Alert

WELCOME!! So that we may provide you with the best possible care, please complete both sides of this medical/dental history form. All information is completely confidential.

What is the reason for your visit today? _____

If you were able to change anything about your smile, what would you change? _____

Date of last Dental Visit _____ **Last Dental Cleaning** _____ **Last Full Mouth X-rays** _____
What was done at your last dental visit? _____

Previous Dentist's Nan_____ State _____ Zip _____
Address _____ Telephone (_____)_____

How often do you have dental examinations?_____
How often do you brush your teeth?_____ How often do you floss? _____
What other dental aids do you use? (Hydrofloss, Electric Toothbrush, Toothpick) _____

Do you have dental problems? Yes ☐ No ☐ If yes, please describe: _____

Please circle the correct response to:

Are any of your teeth sensitive to:		Have you had orthodontic treatment?	☐Yes☐No
Hot or cold?	☐ Yes☐No	Have you had oral surgery?	☐Yes☐No
Sweets?	☐ Yes☐No	Have you had periodontal treatment?	☐Yes☐No
Biting or Chewing?	☐ Yes☐No	Have you had your bite adjusted?	☐Yes☐No
Have you noticed any mouth odors or bad tastes?	☐ Yes☐No	Have you had a mouth guard or bite plate?	☐Yes☐No
Do you frequently get cold sores, blisters or lesions?	☐ Yes☐No	Have you had a serious head or mouth injury?	☐Yes☐No
Do your gums bleed or hurt?	☐ Yes☐No	If so, please describe, including cause:	
Have your parents experienced gum disease of tooth loss?	☐ Yes☐No	_____	
Have you noticed any loose teeth or change in your bite?	☐ Yes☐No	Have you experienced clicking or popping?	☐Yes☐No
Does food tend to get caught between your teeth?	☐ Yes☐No	Have you experienced pain (joint, ear, face)?	☐Yes☐No
If so, where?		Have you had difficulty chewing?	☐Yes☐No
_____		Have you had headaches or neckaches?	☐Yes☐No
Do you clench or grind your teeth?	☐ Yes☐No	Have you had shoulder aches or muscle aches?	☐Yes☐No
Do you bite your lips or cheeks regularly?	☐ Yes☐No	Are you satisfied with your teeth's appearance?	☐Yes☐No
Do you hold foreign objects in your teeth?	☐ Yes☐No	Would you like to keep your teeth for life?	☐Yes☐No
Do you bite your nails?	☐ Yes☐No	Do you feel nervous about dental treatment?	☐Yes☐No
Do you mouth breathe while awake or asleep?	☐ Yes☐No	If so, what is your biggest concern?	
Do you smoke or chew tobacco?	☐ Yes☐No	_____	
		Have you ever had an upsetting dental experience?	☐Yes☐No
		If so, please describe:	
		_____	

Is there anything else about having dental treatment that you would like us to know about? ☐ **Yes** ☐ **No**
If yes, please describe: _____

(Please complete the other side)

Patient Name	**MEDICAL HISTORY**
Patient Account No.	Medical Alert

1. Have you been under the care of a medical doctor during the past two years? ☐Yes ☐No
   If yes, for what? _____
   Physician's Name: _____ Phone: (_____)_____
   Address: _____ City: _____ State:_____ Zip:_____
2. Have you taken any medication or drugs the past two years? Yes☐ No☐
3. Are you taking any medication, drugs or pills now? Yes☐ No☐
   If yes, please list the name and dosage: _____
4. Have you ever taken prescription medications for weight loss (diet pills)? Yes☐ No☐
   If yes, did you take any of the following: Fen-Phen (Fenfluramine-Phenopermine) Yes☐ No☐
   Pondimen (Fenfluramine) Yes☐ No☐
   Redux (Desfenfluramine) Yes☐ No☐
   If yes to any of the above, did you have a medical exam for heart issues? Yes☐ No☐
5. Are you aware of having an allergic (or adverse reaction) to any medication or substance? Yes☐ No☐
   If yes, please list: _____
6. Have you been a patient in the hospital during the past five years? Yes☐ No☐
7. Indicate which of the following you have had, or have at present. Circle "Yes" or "No" for each:

Heart (surgery, disease, attack):	Yes☐No☐	*Ulcers:*	Yes☐No☐	*Hepatitis A or B:*	Yes☐ No☐
Chest Pain:	Yes☐No☐	*Diabetes:*	Yes☐No☐	*Venereal Disease:*	Yes☐ No☐
Congenital Heart Disease:	Yes☐No☐	*Thyroid Problems:*	Yes☐No☐	*A.I.D.S.:*	Yes☐ No☐
Heart Murmur:	Yes☐No☐	*Glaucoma:*	Yes☐No☐	*H.I.V. Positive:*	Yes☐ No☐
High Blood Pressure:	Yes☐No☐	*Contact Lenses:*	Yes☐No☐	*Cold Sores/Blisters:*	Yes☐ No☐
Mitral Valve Prolapse:	Yes☐No☐	*Emphysema:*	Yes☐No☐	*Blood Transfusion:*	Yes☐ No☐
Artificial Heart Valve:	Yes☐No☐	*Chronic Cough:*	Yes☐No☐	*Hemophilia:*	Yes☐ No☐
Heart Pacemaker:	Yes☐No☐	*Tuberculosis:*	Yes☐No☐	*Sickle Cell Disease:*	Yes☐ No☐
Rheumatic Fever:	Yes☐No☐	*Asthma:*	Yes☐No☐	*Bruise Easily:*	Yes☐ No☐
Arthritis/Rheumatism:	Yes☐No☐	*Hay Fever:*	Yes☐No☐	*Liver Disease:*	Yes☐ No☐
Cortisone Medicine:	Yes☐No☐	*Latex Sensitivity:*	Yes☐No☐	*Yellow Jaundice:*	Yes☐ No☐
Swollen Ankles:	Yes☐No☐	*Allergies or Hives:*	Yes☐No☐	*Neurological Disorder:*	Yes☐ No☐
Stroke:	Yes☐No☐	*Sinus Trouble:*	Yes☐No☐	*Epilepsy/Seizures:*	Yes☐ No☐
Diet (special/restricted):	Yes☐No☐	*Radiation Therapy:*	Yes☐No☐	*Fainting/Dizzy Spells:*	Yes☐ No☐
Artificial Joints (hip/knee):	Yes☐No☐	*Chemotherapy:*	Yes☐No☐	*Nervous/Anxious*	Yes☐ No☐
Kidney Trouble:	Yes☐No☐	*Tumors:*	Yes☐No☐	*Psychiatric Care:*	Yes☐ No☐

8. Do you use more than two pillows to sleep? Yes☐ No☐
9. Have you lost or gained more than 10 pounds in the past year? Yes☐ No☐
10. Do you have or have you had any disease, condition, or problem not listed? Yes☐ No☐
    If yes, please list: _____
11. **Women**, are you? **Pregnant** ☐Yes____months No ☐ **Nursing**? Yes☐No☐ **Taking birth control pills**? Yes☐ No☐

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, you may release such information to you.

I will notify the dentist of any change in my health or medication.

I have been given the opportunity to read and review the Federal (HIPAA - Health Insurance Portability and Accountability Act). Other than is stated by the act or where Federal State or Local law requires, my health information will not be disclosed without further written authorization. I may revoke this authorization in writing at any time.

Initial _____

Patient/Guardian Signature: _____ Date: _____

History Review

Dentist Signature: _____ Date: _____