

# DENTAL AND MEDICAL HISTORY

PATIENT NAME: \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

## **IF YOU ANSWER "YES" TO ANY QUESTION, PLEASE EXPLAIN**

- Are you under a physician's care now?  Yes  No \_\_\_\_\_
- Have you ever been hospitalized or had a major operation?  Yes  No \_\_\_\_\_
- Have you ever had a serious head or neck injury?  Yes  No \_\_\_\_\_
- Are you taking any medications, pills, or drugs?  Yes  No \_\_\_\_\_  
(Please include any herbal supplements or diet pills.) \_\_\_\_\_
- Are you on a special diet?  Yes  No \_\_\_\_\_
- Do you use tobacco?  Yes  No      Do you use controlled substances?  Yes  No
- Women:* Are you  Pregnant?  Trying to get pregnant?  Nursing?  Taking oral contraceptives?
- Are you allergic to any of the following?  
 Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics  Other \_\_\_\_\_
- Do you need pre-medication due to heart murmur, rheumatic heart disease, valve replacement, or joint replacement?  Yes  No

Do you have, or have you had, any of the following?

- |  |  |  |   |   |
|--|--|--|---|---|
| <input type="checkbox"/> AIDS/HIV Positive       | <input type="checkbox"/> Chest Pains               | <input type="checkbox"/> Frequent Headaches    | <input type="checkbox"/> Irregular Heartbeat    | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Alzheimer's Disease     | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Genital Herpes        | <input type="checkbox"/> Kidney Problems        | <input type="checkbox"/> Shingles                   |
| <input type="checkbox"/> Anaphylaxis             | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Leukemia               | <input type="checkbox"/> Sickle Cell Disease        |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Convulsions               | <input type="checkbox"/> Hay Fever             | <input type="checkbox"/> Liver Disease          | <input type="checkbox"/> Sinus Trouble              |
| <input type="checkbox"/> Angina                  | <input type="checkbox"/> Cortisone Medicine        | <input type="checkbox"/> Heart Attack/Failure  | <input type="checkbox"/> Low Blood Pressure     | <input type="checkbox"/> Spina Bifida               |
| <input type="checkbox"/> Arthritis/Gout          | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Heart Murmur*         | <input type="checkbox"/> Lung Disease           | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Artificial Heart Valve* | <input type="checkbox"/> Drug Addiction            | <input type="checkbox"/> Heart Pace Maker*     | <input type="checkbox"/> Mitral Valve Prolapse* | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Artificial Joint*       | <input type="checkbox"/> Easily Winded             | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Pain in Jaw Joints     | <input type="checkbox"/> Swelling of Limbs          |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Emphysema                 | <input type="checkbox"/> Hemophilia            | <input type="checkbox"/> Parathyroid Disease    | <input type="checkbox"/> Thyroid Disease            |
| <input type="checkbox"/> Blood Disease           | <input type="checkbox"/> Epilepsy or Seizures      | <input type="checkbox"/> Hepatitis A           | <input type="checkbox"/> Psychiatric Care       | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Blood Transfusion       | <input type="checkbox"/> Excessive Bleeding        | <input type="checkbox"/> Hepatitis B or C      | <input type="checkbox"/> Radiation Treatments   | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Breathing Problem       | <input type="checkbox"/> Excessive Thirst          | <input type="checkbox"/> Herpes                | <input type="checkbox"/> Recent Weight Loss     | <input type="checkbox"/> Tumors or Growths          |
| <input type="checkbox"/> Bruise Easily           | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Renal Dialysis         | <input type="checkbox"/> Ulcers                     |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Frequent Cough            | <input type="checkbox"/> Hives or Rash         | <input type="checkbox"/> Rheumatic Fever*       | <input type="checkbox"/> Venereal Disease           |
| <input type="checkbox"/> Chemotherapy            | <input type="checkbox"/> Frequent Diarrhea         | <input type="checkbox"/> Hypoglycemia          | <input type="checkbox"/> Rheumatism             | <input type="checkbox"/> Yellow Jaundice            |

Have you ever had any serious illness not listed above?  Yes  No

If yes, please explain below:

Comments: \_\_\_\_\_

- |   |   |
|---|---|
| Do you have any specific dental concerns or problems? <input type="radio"/> Yes <input type="radio"/> No    | Have you ever had a scaling/deep cleaning? <input type="radio"/> Yes <input type="radio"/> No             |
| Do you have dental exams on a regular basis? <input type="radio"/> Yes <input type="radio"/> No             | Do you feel nervous about having dental treatment? <input type="radio"/> Yes <input type="radio"/> No     |
| Is your dental health excellent / good / fair / poor? <input type="radio"/> Yes <input type="radio"/> No    | Have you ever had a bad experience in a dental office? <input type="radio"/> Yes <input type="radio"/> No |
| Do you think you have active decay or gum disease? <input type="radio"/> Yes <input type="radio"/> No       | Do you want to keep your remaining teeth? <input type="radio"/> Yes <input type="radio"/> No              |
| Do your gums ever bleed? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Sometimes | Do you like your smile? <input type="radio"/> Yes <input type="radio"/> No                                |
| How many times per day do you brush? _____ Floss? _____   | Are you interested in brighter or whiter teeth? <input type="radio"/> Yes <input type="radio"/> No        |

## AUTHORIZATION AND RELEASE

I certify that the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I consent to examination by a dental provider. I understand that if treatment is recommended I will have the opportunity to ask questions before accepting or refusing treatment. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I allow a photocopy or my signature to be used to process my insurance claim for the period of lifetime. This order will remain in effect until revoked by me in writing. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents, and I further understand that fees are due and payable upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

\_\_\_\_\_  
SIGNATURE OF PATIENT/PARENT/GUARDIAN

\_\_\_\_\_  
DATE