MEDICAL HISTORY FORM

Your Full Name: _____ Nickname: _____

Home Address:_____ Zip Code: _____

Employer: _____ Job Title: _____

Home Phone: _____ Social Security Number: _____-____-_____

Work Phone: _____ Birthday: _____/_____/_____

Cell Phone: _____ Gender: M / F

Marital Status: _____ Email:_____

Is your spouse currently a patient? If so what is their name:_____

What is your primary reason or concern for contacting us? _____

Approximate last date of dental visit: _____ Reason: _____

Referral Information: Who may we thank for referring you to our practice? _____

Please check any/all conditions that apply:

☼ HIV / AIDS	☼ Codeine Allergy	☼ Dental Implants
☼ Latex Allergy	☼ Penicillin Allergy	☼ Periodontal Disease (past/current)
☼ Artificial Joint/s	☼ Arthritis	☼ History of Root Canal/s
☼ Asthma	☼ Blood Disease	☼ History of Orthodontics (braces/Invisalign)
☼ Cancer	☼ Diabetes	☼ Have your wisdom teeth extracted?
☼ Dizziness	☼ Epilepsy	☼ Teeth Whitening (in-office / trays / strips)
☼ Excessive Bleeding	☼ Fainting	☼ Use an electric toothbrush?
☼ Glaucoma	☼ Defibrillator	☼ Hay Fever
☼ Head Injury	☼ Heart Disease	☼ Heart Murmur
☼ Hepatitis	☼ Jaundice	☼ Kidney Disease
☼ Liver Disease	☼ Mental Disorder/s	☼ Pacemaker
☼ Nervous Disorders	☼ Radiation Treatment	☼ Respiratory Problems

☼ High/Low Blood Pressure ☼Smoke or other tobacco use?

Do you have any other condition not listed above or significant dental or general health problem that may need further clarification?

☼ No ☼ Yes If yes, please briefly explain: _____

Do you have any allergies? ☼ No ☼ Yes

If yes, please list name and reaction: _____

Are you currently taking any medications? ☼ No ☼ Yes

If yes, please list: _____

Have you ever had to take pre-medication prior to a

dental appointment, such as antibiotic prophylaxis? ☼ No ☼ Yes

If yes, please briefly explain:_____

Have you ever had any complications following dental treatment? ☼ No ☼ Yes

If yes, please briefly explain: _____

Have you recently been admitted to the hospital or needed emergency care? ☼ No ☼ Yes

If yes, please briefly explain: _____

Are you currently under the care of a physician? ☼ No ☼ Yes

If yes, name of physician: _____ Phone: _____

Reason:_____

Women:

Is there a possibility you are currently pregnant? ☼ No ☼ Yes

If yes, please provide current trimester: _____ estimated due date: _____

In Case of Emergency, whom should we contact on your behalf?

Name: _____ Phone: _____

Help us help you:

1. Are you interested in whitening your teeth? Y / N

2. Are you interested in straightening your teeth? Y / N

3. Are you interested in improving your smile? Y / N

4. Are you interested in knowing more about the benefits of an electric toothbrush? Y / N

5. Are you interested in replacing missing teeth? Y / N

6. Do you grind or clench your teeth? Y/ N

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's health). It is my responsilbility to inform the dental office of any changes in medical status

Singature of patient, parent or guardian:_____ Date:_____

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