Medical History

Date____________________

Patient Information

First Name: ______________________ Middle Initial: __________ Last Name: ______________________

Address: ______________________

Home Phone: ______________________ Cell Phone: ______________________

Date of Birth: ______________________ Sex: ______________________

Emergency Contact: ______________________ Phone #: ______________________

Who do we have the pleasure to thank for referring you to us? ______________________

Primary Insurance Information

Policy Holder's Name: ______________________ Relationship to Patient: __________

Address: ______________________ Phone Number: __________

Date of Birth: ______________________ ID Number: ______________________

Employer: ______________________ Dental Insurance Company: ______________________

Mailing Address: ______________________ Group #: __________

Secondary Insurance Information

Policy Holder's Name: ______________________ Relationship to Patient: __________

Address: ______________________ Phone Number: __________

Date of Birth: ______________________ ID Number: ______________________

Employer: ______________________ Dental Insurance Company: ______________________

Mailing Address: ______________________ Group #: __________

Medical Information

Physician's Name: ______________________

City: ______________ Prov: __________ Phone: ______________ Date of Last Visit: __________

Are you currently undergoing any medical treatment with a physician? If so, what for? ______________________

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Have you had any surgeries? If so, please list. ______________________

Yes	No	**Please mark an X for the following questions accordingly. Please explain any YES answers in the designated area below.**
		Do you have any Eye, Ear, Nose or Throat problems? (Ex. Cataract, Glaucoma, Hearing Impairment, etc.)
		Do you have any Heart or Blood Pressure problems? (Ex. Artificial Valves, Congenital Heart Disease, etc.)
		Do you have any Breathing or Lung problems? (Ex. Asthma, COPD, Sleep apnea, Pneumonia, etc.)
		Do you have any Stomach, Intestine, or Liver disorders? (Ex. Crohn's, Acid Reflux, Celiac's, IBS, etc.)
		Do you have an Eating disorder? (ex. Bulimia, Anorexia, Purging, etc.)
		Do you have any Kidney or Urinary disorders? (Ex. Renal Failure, Urinary Incontinence, etc.)
		Do you have any Muscle or Bone disorders? (ex. Osteoarthritis, Gout, TMJ, Fibromyalgia, etc.)
		Do you have any skin problems? (Ex. Eczema, Psoriasis, etc.)
		Do you have any Neurologic or Nerve problems? (Ex. Stroke, Seizures, Parkinson's, Alzheimer's, etc.)
		Do you have any Mental Health disorders? (Ex. Depression, PTSD, Bipolar, Anxiety, etc.)
		Do you have any Diabetes or Endocrine disorders? (Ex. Type 1, Type 2, Thyroid Problems, etc.)
		Do you have any Blood or Hematologic disorders? (Ex. Anemia, Leukemia, Sickle Cell, etc.)
		Do you have any Immune System disorders? (Ex. Lupus, Rheumatoid arthritis, etc.)
		Do you have any Infectious diseases? (Ex. Hepatitis A, B/D, or C, STD, HIV/AIDS, cold sores, etc.)
		Do you have any joint replacements? (Ex. Hip, Knee, Shoulder, Elbow, Ankle, etc.)
		Do you use any tobacco products, illicit drugs, or alcohol? If yes, what and how often?
		Do you pre-medicate prior to Dental Treatment for any of the following reasons? Artificial Heart Valve, Previous Infective Endocarditis, Heart Transplant, Congenital Heart Disease

Please explain any YES answers from the previous list of questions:

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Yes	No	FEMALES ONLY
		Are you or could you be pregnant? If yes, how many weeks?
		Are you currently nursing?
		Are you taking any birth control, Fertility Drugs or Hormone replacements?

Do you currently take any medications? Prescription, over the counter, dietary supplements, herbal medicine or vitamins? (If you have more than five medications, we would be happy to make a copy of your list for you)

Medications or Supplements	Dose	Frequency	Date Started	Reason for Use

Please list any allergies to any medications, metals, latex, or food?______________________________

Dental Information

Previous Dentist:______________________________ Date of Last Dental Exam:______________

Address______________________________ Office Phone:______________

Do you have current x-rays that you would like transferred to our office? Yes/No______________

How do you feel about your current smile?______________________________

Yes	No	**Please mark an X for the following questions accordingly.**
		Do you brush your teeth twice daily? If no, how often?
		Do you floss or Waterpik daily? If no, how often?
		Do your gums bleed when you brush and floss?
		Are your teeth sensitive to hot, cold, sweets or pressure?
		Is your mouth dry?
		Have you had any perio (gum) treatments? If yes, When?
		Have you gone through orthodontic (braces) treatment? If yes, When?
		Is your home water supply fluoridated?
		Do you have any earaches or neck pain?
		Do you have any popping, clicking or discomfort in your jaw?
		Do you brux, clench, or grind your teeth?
		Do you have any sores or ulcers in your mouth?
		Do you wear partials or dentures? If yes, when were they last made?

Note: Both Patient and Doctor are encouraged to discuss any and all relevant health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and the staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or the staff responsible for any action they take or do not take because or errors or omissions that I may have made in the completion of this form.

Signature of Patient/Guardian:____