Medical & Dental History Form

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in good health? ☐ Yes ☐ No

Within the past year, have there been any changes in your general health? ☐ Yes ☐ No

What is the date (or approximate date) of your last medical exam?

Your Primary Care Physician's name, address, & phone number:

Please mark any of the following with Y (yes) or N (no)s in response to the question:

- Have you ever had complications following dental treatment? ☐
- Are you currently under the care of a physician due to a specific condition? ☐
- Have you been hospitalized within the last 5 years due to a surgery or illness? ☐
- Are you currently taking any prescription or non-prescription medications? ☐
- Do you use tobacco (smoking, chewing, or vaping)? ☐
- Do you require the use of corrective lenses (contacts or glasses)? ☐
- Do you have any other conditions, diseases, etc., not listed above that we should be aware of? ☐
- Do you have any sleeping disorders, breathing issues, or snoring? ☐

If you answered Yes to any of the above questions, please provide us with more details

WOMEN ONLY:

Are you pregnant? ☐ Yes ☐ No

If Yes, when is the due date?

Are you currently trying to conceive? ☐ Yes ☐ No

Please indicate if you have experienced any of the following:

- [ ] Allergies
- [ ] Allergy Lisinopril
- [ ] Allergy to Ibuprofen
- [ ] Allergy to Metal
- [ ] Allergy to Vicodin
- [ ] Allergy to Antibiotic
- [ ] Asthma
- [ ] Cephalexin
- [ ] Drug Addiction
- [ ] Fibromyalgia
- [ ] Head Injuries
- [ ] Heart Trouble, other
- [ ] Joint Replacement
- [ ] Low Blood Pressure
- [ ] Osteoporosis
- [ ] Radiation Treatment
- [ ] Seizures
- [ ] Sleep Disorder
- [ ] Thyroid Disease
- [ ] Venereal Disease
- [ ] Allergy Amoxicillin
- [ ] Allergy PENICILIN
- [ ] Allergy to Iodine
- [ ] Allergy to Novocaine
- [ ] Allergy to Codeine
- [ ] Antibiotic Allergy Levaquin
- [ ] Autism
- [ ] Depression
- [ ] Epilepsy
- [ ] Fosamax
- [ ] Heart Bypass
- [ ] Hepatitis A, B or C
- [ ] Kidney Disease
- [ ] Mental Disorders
- [ ] Other/See MH
- [ ] Respiratory Problems
- [ ] Sinus Problems
- [ ] Stomach Problems
- [ ] Tuberculosis
- [ ] Allergy Barbiturates
- [ ] Allergy to Aspirin
- [ ] Allergy to Latex
- [ ] Allergy to Sedatives
- [ ] Anaemia
- [ ] Arthritis
- [ ] Blood Disease
- [ ] Diabetes
- [ ] Excessive Bleeding
- [ ] Glaucoma
- [ ] Heart Disease
- [ ] Leukaemia
- [ ] High Blood Pressure
- [ ] Nervous Disorders
- [ ] PRE-MEDICATE!
- [ ] Rheumatic Fever
- [ ] Sjogren's Disease
- [ ] Stroke
- [ ] Tumours
- [ ] Allergy Erythromycin
- [ ] Allergy – Hay Fever
- [ ] Allergy to Lodine
- [ ] Allergy to Sulpha
- [ ] Anaesthetic Reaction
- [ ] Artificial Joints
- [ ] Cancer
- [ ] Dizziness
- [ ] Fainting
- [ ] HIV
- [ ] Heart Murmur
- [ ] Jaundice
- [ ] Liver Disease
- [ ] Nursing
- [ ] Pacemaker
- [ ] Rheumatism
- [ ] Sleep Apnoea
- [ ] Thyroid Problem
- [ ] Ulcers

Do you have any other health issues or allergies?

What is the reason for your dental visit today?

When was your last visit to the dentist (if to a different office)?

What was done on your last dental visit (if to a different office)?

Prior Dentist's name, address, & phone number:

How frequently do you brush your teeth?

☐ 3(+) a day ☐ Twice a day ☐ Once a day ☐ Weekly ☐ Seldom

How frequently do you floss or irrigate your teeth?

☐ 3(+) a day ☐ Twice a day ☐ Once a day ☐ Weekly ☐ Seldom

Please mark any of the following with Y (yes) or N (no)s in response to the question:

Do your gums bleed when you brush or floss?	☐
Do your teeth experience sensitivity to cold or hot temperatures?	☐
Are any of your teeth currently causing you pain?	☐
Do you grind or clench your teeth (either consciously or during sleep)?	☐
Are any of your teeth loose, or are you concerned about any teeth loosening?	☐
Do you currently have any dental implants, dentures, partials, or other dental appliances?	☐
Are you currently in or have had any orthodontic treatment?	☐
Do you feel rested after a night's sleep?	☐
Do you snore?	☐
Have you had tonsils or adenoid removal?	☐
Have you ever had a sleep study?	☐
Do you wake up with a dry mouth in the morning, or through out the day?	☐

If you replied Yes to any of the previous questions, please explain:

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.
I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.
I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party service providers and healthcare practitioners.
I understand that I am financially responsible for any outstanding balance for services provided.
I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient: Date: