

# YOUR MEDICAL AND DENTAL HISTORY

## Tell us about yourself.



We need this information to ensure your safety and health and the best possible dental care for you. All information is kept confidential among only our staff, your emergency contacts, and, if necessary, your doctor.

Mr.	Mrs.	Miss	Ms.	Dr.	Name
Home #					Address (include city + postal code)
Work #					
Cell #					
Email					

Date of birth	Whom may we thank for referring you?
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In case of emergency call:	Responsibility for your account
Name	Do you have dental insurance?      YES      NO (Please bring this information with you to the office)
Relationship	Where you work
Home #	Name of person responsible for your account, if not yourself:
Work #	
Cell #	Relationship

YES	NO	Your medical history
		1. Are you presently under the care of a physician? Reason:
		2. Are you currently taking any medications? Please list.
		3. Have you been hospitalized in the last 5 years? Reason:
		4. Have you ever been prescribed antibiotic coverage before a dental appointment?
		5. Are you allergic to any medications? Please list:
		6. Do you smoke? If yes, how many per day?
		7. (Women) Are you pregnant or suspect you might be?
		8. (Women) Are you taking birth control pills?
		9. (Women) Are you taking supplementary hormones?

### Check all that apply to your medical history.

Angina/chest pain <input type="checkbox"/>	Lung disease <input type="checkbox"/>	Blood disorder <input type="checkbox"/>	Kidney disease <input type="checkbox"/>
Joint replacement <input type="checkbox"/>	HIV/AIDS <input type="checkbox"/>	Stomach ulcers <input type="checkbox"/>	Thyroid disease <input type="checkbox"/>
Arthritis <input type="checkbox"/>	Epilepsy <input type="checkbox"/>	Cold sores <input type="checkbox"/>	Liver disease <input type="checkbox"/>
Rheumatic fever <input type="checkbox"/>	Asthma <input type="checkbox"/>	Diabetes <input type="checkbox"/>	Bleed easily <input type="checkbox"/>
Organ transplant <input type="checkbox"/>	Canker sores <input type="checkbox"/>	Hepatitis A, B, C <input type="checkbox"/>	Bruise easily <input type="checkbox"/>
Sinus problems <input type="checkbox"/>	Cancer <input type="checkbox"/>	Artificial heart valve <input type="checkbox"/>	Fever blisters <input type="checkbox"/>
Heart attack/failure <input type="checkbox"/>	Congenital heart disorder <input type="checkbox"/>	Pacemaker/defibrillator <input type="checkbox"/>	Blood pressure problems <input type="checkbox"/>
	Heart murmur <input type="checkbox"/>		

Your physician 's name and city:

## Your dental history

Check all that apply to your dental history.

Date of last dental visit

Treatment you received

Date of last X-rays

How often do you brush?

How often do you floss?

Do you use other hygiene aids?

Gum therapy

Gum surgery

Dentures

Implants

Orthodontics

Silver fillings

Root canal

Tooth extractions

Injury to face or jaw

Surgery to face or jaw

Cosmetic (whitening, bonding)

Crowns or veneers

Fixed bridges

Root therapy or treatment

YES	NO	Your bite		YES	NO
		Do you grind or clench your teeth?		Do you awaken with headaches?	
		Have you noticed chipped or worn edges on your teeth?		Is it difficult to open or close your jaw?	
		Has a dentist adjusted the way your teeth fit together?		Do you hear clicking/popping sounds when chewing?	
YES	NO	Your gums		YES	NO
		Are your gums swollen or tender?		Are there any sore spots in your mouth?	
		Do you experience bad breath?		Are you aware of any loose teeth?	
		Do your gums bleed when you eat, brush, or floss?		Are any teeth sensitive to heat, cold, sweets, pressure?	
YES	NO	Your smile		YES	NO
		Are you interested in improving your smile?		Would you like to have whiter teeth?	

## Your signature

By signing below you agree that you:

- have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information
- have had the opportunity to ask questions and receive answers about your medical-dental history
- authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care
- understand that consultation with your medical doctor may be required, and you consent to your physician being contacted if necessary
- understand that responsibility for payment for the dental services provided for you or your dependents is yours, and you will assume responsibility for fees associated with these services.

YOUR SIGNATURE

DATE

SIGNATURE of PARENT or GUARDIAN

PRINT NAME of PARENT or GUARDIAN