



Patient, Medical, & Dental Information

Welcome to our office. We appreciate the confidence you place with us to provide you with dental services. To assist us in serving you please complete the following forms. The medical information you provide us with is important to your dental health. If there have been any changes to your health, please tell us. If you have any questions or need help to fill out the form, don't hesitate to ask.

Date: _____

Patient Name: _____ Date of Birth: _____ Male Female

Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____ Email: _____ SS#: _____

Home #: _____ Cell #: _____ Work #: _____

Spouse's Name & Phone: _____

Emergency Contact Name & Phone (other than spouse): _____

Primary Dental Insurance: _____ Insurance ID #: _____ Group #: _____

Subscriber's Name: _____ DoB: _____ SS#: _____

Subscriber's Employer: _____

Secondary Dental Insurance: _____ Insurance ID #: _____ Group #: _____

Subscriber's Name: _____ DoB: _____ SS#: _____

Subscriber's Employer: _____

Name of your Medical Doctor: _____ Last Visit: _____

Name of Previous Dentist: _____ Last Visit: _____

Referred to us by: _____

Are you aware of any particular dental problems/anything that bothers you about your smile, teeth, or mouth? _____

Are you having any pain or discomfort? _____

Is any antibiotic premedication required by your physician? _____

Please list any surgeries, hospitalizations, or serious illnesses you have had:

Please list any medications you are taking including over the counter medications:

Do you have or have ever had any of the following

Heart Problems

	Yes	No
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>
A Fib	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>
Take a blood thinner (e.g Aspirin, Plavix, Coumadin, Eliquis)	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Swollen ankles	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>
Heart valve problems	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valve	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		
Stroke, TIAs	<input type="checkbox"/>	<input type="checkbox"/>

Blood Disorders

Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Bruises easily	<input type="checkbox"/>	<input type="checkbox"/>
Frequent nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Prolonged healing	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>
HIV Positive/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

Allergies

Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Skin rashes	<input type="checkbox"/>	<input type="checkbox"/>
Anaphylactic shock	<input type="checkbox"/>	<input type="checkbox"/>
Carry an Epi-Pen	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>

Are you allergic or have you reacted adversely to any of the following?

	Yes	No
Local Anesthetics ("Novocaine")	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or any other Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>
Antidepressants, Barbiturates, Sedatives, or Sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin, Acetaminophen, or Ibuprofen	<input type="checkbox"/>	<input type="checkbox"/>
Codeine, Demerol, or other Narcotics	<input type="checkbox"/>	<input type="checkbox"/>
Reactions to Metals	<input type="checkbox"/>	<input type="checkbox"/>
Latex	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

Intestinal Problems

GERD

YES

NO

Special diet

Other _____

Kidney or Bladder Problems

Other _____

Liver Disease

Jaundice

Hepatitis B

Hepatitis C

Other _____

Bone or Joint Problems

Arthritis

Back or Neck Pain

Osteoporosis

Did you ever take osteoporosis medication?

If yes, what kind? _____

Orthopedic Joint Replacement (e.g. Hip, knee, shoulder, pins, or implants)

If yes, what kind and when? _____

Does your orthopedic surgeon require you to pre-medicate before dental work?

Name & Phone # of Orthopedic Surgeon _____

Diabetes

If yes, Type 1 or Type 2 _____

Urinate more than 6 times a day

Thirsty or mouth is dry much of the time

Family history of diabetes

Take diabetes medication/insulin

Oncology

Cancer

If yes, what kind and when? _____

Radiation treatment

Chemotherapy treatment

Persistent cough or swollen glands

Sores that do not heal

Lung & Respiratory Disease

Tuberculosis

COPD

Other _____

Autoimmune Disease

If yes, what kind? _____

Thyroid Disease

Neurological Disorders

If yes, what kind? _____

Epilepsy

Fainting spells or seizures

Frequent or severe headaches

History of head trauma

Mental or Emotional/Behavioral Disorder

	Yes	No
Autism or Asperger's Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
ADD or ADHD	<input type="checkbox"/>	<input type="checkbox"/>
Bulimia or Anorexia (or any eating disorder)	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
History of mental disorder (bipolar disorder, schizophrenia, etc.)	<input type="checkbox"/>	<input type="checkbox"/>

Other _____

Did you even have an organ transplant? Yes No
If yes, what kind and when? _____

Eyes

Glaucoma or other eye disorder	<input type="checkbox"/>	<input type="checkbox"/>
Herpes or other STD	<input type="checkbox"/>	<input type="checkbox"/>

Women

	Yes	No
Are you taking contraceptives or other hormones?	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant? If so, expected delivery date _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you reached menopause? If so, do you have any symptoms?	<input type="checkbox"/>	<input type="checkbox"/>

Do or did you ever use tobacco? Yes No

Please circle appropriate one(s): cigarettes, cigars, chewing tobacco, or vaping

For how long and how often do/did you use tobacco? _____

Are you interested in stopping your tobacco use? Yes No

Do you use Marijuana (in any form)? Yes No

Do you drink alcohol? Yes No
If so, how often? _____

Do you have a history of alcohol and/or drug abuse? Yes No

Do you have any disease, condition, or problem not listed previously that you feel we should know about?

Are you apprehensive about dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Do you gag easily?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have difficulty chewing your food?	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
Do you get cold sores?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever noticed slow healing sores in your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed easily (when you floss or brush)?	<input type="checkbox"/>	<input type="checkbox"/>
Do you take fluoride supplements?	<input type="checkbox"/>	<input type="checkbox"/>
How often do you brush _____ floss _____		
Are you aware of clenching or grinding your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear a night guard?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any jaw symptoms or headaches upon waking in the morning?	<input type="checkbox"/>	<input type="checkbox"/>
Do you take medication for pain or discomfort in your mouth, teeth, or jaw?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a blow or trauma to the jaw?	<input type="checkbox"/>	<input type="checkbox"/>
Do you experience dry mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Are you vaccinated against HPV? (Human Papilloma Virus)	<input type="checkbox"/>	<input type="checkbox"/>

Patient/Parent Signature: _____ Date: _____

Dental Hygienist Initial: _____

Dentist Initial: _____

For Dentist & Hygienist Only

Notes:

Medical Updates:

Date:

