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 ☐

Home Address: ______________________________ City: __________________ State: ______ Zip: _______

Occupation: _____________________ E-Mail: ____________________________ SS#: _____________________

Home phone: ______________________Mobile: _______________________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? ____

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:

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

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Do you have or have ever had any of the following

Heart Problems	**Yes**	**No**
Chest pain	☐	☐
Shortness of breath	☐	☐
A Fib	☐	☐
Heart attack	☐	☐
Take a blood thinner (e.g. Aspirin, Plavix, Coumadin)	☐	☐
High blood pressure	☐	☐
Low blood pressure	☐	☐
Swollen Ankles	☐	☐
Heart murmur	☐	☐
Heart valve problems	☐	☐
Artificial heart valve	☐	☐
Pacemaker	☐	☐
Defibrillator	☐	☐
Rheumatic Fever	☐	☐
Other ____________________		
Stroke, TIAs	☐	☐
Blood Disorders		
Anemia	☐	☐
Bruises easily	☐	☐
Frequent nosebleeds	☐	☐
Abnormal Bleeding	☐	☐
Prolonged healing	☐	☐
Leukemia	☐	☐
HIV Positive/ AIDS	☐	☐
Other ____________________		
Allergies		
Hay fever	☐	☐
Asthma	☐	☐
Skin rashes	☐	☐
Anaphylactic shock	☐	☐
Carry an Epi-Pen	☐	☐
Sinus problems	☐	☐

Are you allergic or have you reacted adversely to any of the following?	**Yes**	**No**
Local Anesthetics ("Novocain")	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Antidepressants, Barbiturates, Sedatives, or Sleeping pills	☐	☐
Aspirin, Acetaminophen, or Ibuprofen	☐	☐
Codeine, Demerol, or other Narcotics	☐	☐
Reactions to Metals	☐	☐
Latex	☐	☐
Other ____________________		

Intestinal Problems	**Yes**	**No**
GERD	☐	☐
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 Orthopedic Surgeon______________________________		
Diabetes	☐	☐
If yes, Type 1 or 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? ______________________________		
Radiation treatment	☐	☐
Chemo 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 disorder? ______________________________		
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	☐	☐
ADD or ADHD		
Bulimia or Anorexia	☐	☐
Depression	☐	☐
Anxiety	☐	☐
History of mental disorder (polar disorder, schizophrenia etc.).	☐	☐

Other ____

Did you ever have an organ transplant? ☐ ☐
If yes, what kind & when?________________________________

Eyes

Glaucoma or other eye disorder ☐ ☐

Herpes or other STD ☐ ☐

Women	Yes	No
Are you taking contraceptives or other hormones?	☐	☐
Are you pregnant? If so, expected delivery date__________	☐	☐
Have you reached menopause	☐	☐
If so, do you have any symptoms?	☐	☐

Do or did you ever use tobacco? ☐ ☐

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? ☐ ☐

Do you use Marijuana? ☐ ☐

Do you drink alcohol? ☐ ☐
If so, how often? ____

Do you have a history of alcohol and/or drug abuse? ☐ ☐

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

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	Yes	No
Are you apprehensive about dental treatment?	☐	☐
Do you gag easily?	☐	☐
Do you have difficulty chewing your food?	☐	☐

Do you get cold sores?	☐	☐
Have you ever noticed slow healing sores in your mouth?	☐	☐
Are your teeth sensitive?	☐	☐
Do your gums bleed easily (when you floss or brush)?	☐	☐
Do you take fluoride supplements?	☐	☐
How often do you brush_______________ floss __________________		
Are you aware of clenching or grinding your teeth?	☐	☐
Do you wear a night guard?	☐	☐
Do you have any jaw symptoms or headaches upon wakening in the morning?	☐	☐
Do you take medication for pain or discomfort in mouth, teeth or jaw?	☐	☐
Have you ever had a blow or trauma to the jaw?	☐	☐
Do you experience dry mouth?	☐	☐
Are you vaccinated against HPV? (Human Papilloma Virus)	☐	☐

Patient/ Parent Signature: ____ Date: _________

Dental Hygienist Initial: ___________

Dentist Initial: ____________

For Dentist and Hygienists only
Notes:

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Medical Updates:

Date:

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