Name _____ Phone _____ Email _____

Medical History

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone #: _____ Date of last visit: _____

Your current physical health is: ☐ Good ☐ Fair ☐ poor

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Are you taking any prescription/over-the-counter drugs? ☐ Yes ☐ No

Please list each one: _____

For Women: *Are you taking birth control pills?* ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No *Week #:* ____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following

Y	N	Diseases or medical problems	Y	N	
○	○	Anemia / Radiation Treatment	○	○	Heart Surgery / Pacemaker
○	○	Artificial Bones / Joints	○	○	Hemophilia/Abnormal Bleeding
○	○	Artificial Valves	○	○	Hepatitis
○	○	Asthma / Arthritis	○	○	High / Low Blood Pressure
○	○	Blood Transfusion	○	○	HIV+ / AIDS
○	○	Cancer / Chemotherapy	○	○	Hospitalized for any reason
○	○	Congenital Heart Defect	○	○	Kidney Problems
○	○	Diabetes / Tuberculosis (TB)	○	○	Mitral Valve Prolapse
○	○	Difficulty Breathing	○	○	Psychiatric Problems
○	○	Drug / Alcohol Abuse	○	○	Rheumatic / Scarlet Fever
○	○	Emphysema / Glaucoma	○	○	Severe / Frequent Headaches
○	○	Epilepsy/Seizures/Fainting Spells	○	○	Sinus Problems
○	○	Fever Blisters / Herpes	○	○	Ulcers / Colitis
○	○	Heart Attack / Stroke	○	○	Venereal Disease
○	○	Heart Murmur			

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

Y	N		Y	N		Y	N	
○	○	Aspirin	○	○	Erythromycin	○	○	Tetracycline
○	○	Codeine	○	○	Latex, Rubber	○	○	Oher
○	○	Local Anesthetics	○	○	Penicillin			

Please list any other drugs that you are allergic to: _____

_____

Dental History

Previous/present dentist Name: _____

Phone #: _____ Location: _____

Last Cleaning Date: _____

Do you now or have you ever experienced pain! discomfort in your jaw joint (TMJITMD)? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

How many times a week do you brush?_____ Floss?_____

Have you lost any teeth? ☐ Yes ☐ No If yes, why? _____

Have you ever had any of the following?	**Yes**	**No**
Do your gums bleed while brushing or flossing?	☐	☐
Tooth sensitivity to heat or cold?	☐	☐
Tooth sensitivity to sweet or sour liquids/foods?	☐	☐
Pain in any of your teeth	☐	☐
Sores or lumps in or near your mouth	☐	☐
Head, neck or jaw injuries?	☐	☐
Any clicking, pain, or difficulty opening, closing or chewing in your jaw?	☐	☐
Frequent headaches?	☐	☐
Clenching or grinding your teeth?	☐	☐
Frequent biting of cheeks or lips?	☐	☐
experienced a difficult extraction or prolonged bleeding following?	☐	☐
orthodontic treatment	☐	☐

Additional Comments:

_____

_____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

Signature: _____ Date: _____

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein. Reviewed with _____ Date: _____

Doctor's Comments: _____

_____

MEDICAL HISTORY UPDATE

I have read my medical history dated _____ and confirmed that it states past and present medical conditions.

_____ _____

Signature Date

I have read my medical history dated _____ and confirmed that it states past and present medical conditions.

_____ _____

Signature Date

I have read my medical history dated _____ and confirmed that it states past and present medical conditions.

_____ _____

Signature Date