PATIENT MEDICAL HISTORY Name:

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_ Date of Last Exam: \_\_\_\_\_\_\_\_\_

Have you ever been told you have one of the following? Check only if answer is yes.

\_\_\_\_ Heart Disease \_\_\_\_ Anemia \_\_\_\_ Asthma

\_\_\_\_ Heart Attack \_\_\_\_ Bleeds Easily \_\_\_\_ Shortness of Breath

\_\_\_\_ Heart Murmur \_\_\_\_ Fainting/Seizures \_\_\_\_ Swollen Ankles

\_\_\_\_ Chest Pain – Angina \_\_\_\_ Epilepsy/Convulsions \_\_\_\_ Hay Fever/Allergies

\_\_\_\_ Congenital Heart Defect \_\_\_\_ Arthritis \_\_\_\_ Emphysema

\_\_\_\_ Rheumatic Fever \_\_\_\_ Joint Replacement/Implant \_\_\_\_ Recent Weight Loss

\_\_\_\_ High Blood Pressure \_\_\_\_ Liver Disease \_\_\_\_ Diabetes

\_\_\_\_ Low Blood Pressure \_\_\_\_ Hepatitis \_\_\_\_Cancer

\_\_\_\_ Stroke \_\_\_\_ Jaundice \_\_\_\_ Radiation Therapy

\_\_\_\_ Thyroid Disease \_\_\_\_ Glaucoma \_\_\_\_ Psychiatric Treatment

\_\_\_\_ Stomach Ulcer \_\_\_\_ Leukemia \_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Mitral Valve Prolapse \_\_\_\_ AIDS/HIV \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ Sexually Transmitted Disease \_\_\_\_ Kidney Disease \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

YES NO

\_\_\_ \_\_\_ 1. Are you under medical treatment now? Why: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ \_\_\_ 2. Have you ever had any other serious illness not listed above? What: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ \_\_\_ 3. Are you currently taking any medications? What: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ \_\_\_ 4. Have you ever had a bad reaction to local anesthetic or penicillin? What: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ \_\_\_ 5. Do you use tobacco? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ \_\_\_ 6. Do you use Alcohol, Cocaine or other drugs? What: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_ \_\_\_ 7. Women Only: Are you pregnant or think you may be pregnant? What month: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you taking birth control pills? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PATIENT DENTAL HISTORY

What is your reason for seeking care at this time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have regular dental checkups? When was your last dental exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any pain or discomfort now? What: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do your gums bleed? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have you had surgery performed on your gums? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a root canal? \_\_\_\_\_\_\_\_\_ Have you ever worn braces? \_\_\_\_\_\_\_\_ Do you wear Dentures? \_\_\_\_\_\_

Do you grind your teeth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have you ever had any trauma to your face or mouth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you floss? How often: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many times a day do you brush your teeth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

I also understand that I am responsible for any account balance and payment in full is expected at time of service, unless prior arrangements have been made. As a courtesy to our patients, your insurance claims will be completed for you. However, Insurance is between you and your insurance company. You are still responsible for any unpaid or denied claims.

All information is HIPPA compliant and will only be disclosed for medical or dental treatment.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient/Parent or Guardian