

1. Patient Name (Last, First, MI)

Address

Date of Birth

Home Phone

Social Security Number

Dental Insurance Company and policy number

MEDICAL AND DENTAL INFORMATION

Employer

Work Phone

2. Do you have any dental problems now?

If yes, please describe:

3. Are you taking any medication, drugs or pills now? Yes No

If yes, please list name and dosage

4. Are you aware of having an allergic (or adverse reaction) to any medication or substance? Yes No

If yes, please list:

5. Have you been a patient in the hospital during the past five years? Yes No

6. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

- Heart (Surgery, Disease, Attack) Yes No Ulcers Yes No Hepatitis A (infectious) B (serum) Yes No
Chest Pain Yes No Diabetes Yes No Venereal Disease Yes No
Congenital Heart Disease Yes No Thyroid Problems Yes No A.I.D.S. Yes No
Heart Murmur Yes No Glaucoma Yes No H.I.V. Positive Yes No
High Blood Pressure Yes No Contact lenses Yes No Cold Sores/Fever Blisters Yes No
Mitral Valve Prolapse Yes No Emphysema Yes No Blood Transfusion Yes No
Artificial Heart Valve Yes No Chronic Cough Yes No Hemophilia Yes No
Heart Pacemaker Yes No Tuberculosis Yes No Sickle Cell Disease Yes No
Rheumatic Fever Yes No Asthma Yes No Bruise Easily Yes No
Arthritis/Rheumatism Yes No Hay Fever Yes No Liver Disease Yes No
Cortisone Medicine Yes No Latex Sensitivity Yes No Yellow Jaundice Yes No
Swollen Ankles Yes No Allergies or Hives Yes No Neurological Disorders Yes No
Stroke Yes No Sinus Trouble Yes No Epilepsy or Seizures Yes No
Diet (Special/ Restricted) Yes No Radiation Therapy Yes No Fainting or Dizzy Spells Yes No
Artificial Joints (hip, knee, etc.) Yes No Chemotherapy Yes No Nervous/Anxious Yes No
Kidney Trouble Yes No Tumors Yes No Psychiatric/Psychological Care Yes No

7. Are you now under the care of a physician? Yes No

8. Have you lost or gained more than 10 pounds in the past year? Yes No

9. Do you have or have you had any disease, condition, or problem not listed? Yes No

If yes, please list:

10. Women. Are you: Pregnant? Yes, ___ Months No Nursing? Yes No Taking birth control pills? Yes No

Have you ever had:

- Orthodontic treatment? Yes No
Oral surgery? Yes No
Periodontal treatment? Yes No
Your teeth ground or the bite adjusted? Yes No
A bite plate or mouth guard? Yes No
A serious injury to the mouth or head? Yes No

Have you experienced:

- Clicking or popping of the jaw? Yes No
Pain? (joint, ear, side of face) Yes No
Difficulty in opening or closing the mouth? Yes No
Difficulty in chewing on either side of the mouth? Yes No
Headaches, neckaches or shoulder aches? Yes No
Sore muscles (neck, shoulders)? Yes No

If so, please describe, including cause

Are you satisfied with your teeth's appearance? Yes No
Would you like to keep all of your teeth all of your life? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient /Guardian Signature Date

History Review