ADULT MEDICAL HISTORY

DENTAL INSURANCE

TODAY'S DATE: _____

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ BUSINESS PHONE: _____

CELL PHONE: _____ EMAIL ADDRESS: _____

EMPLOYER: _____

BUS. ADDRESS: _____ CITY: _____

S.S. #: _____ BIRTH DATE: _____

SEX: ☐ MALE ☐ FEMALE MARITAL STATUS: _____

WHO MAY WE THANK FOR REFERRING YOU? _____

_____

WHO IS RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT: _____

_____

DENTAL INSURANCE (Primary): _____

NAME: _____ RELATIONSHIP: _____

S.S. #: _____ INSURANCE ID# _____

DATE OF BIRTH: _____

EMPLOYER: _____ CITY: _____ ST: _____

DENTAL INSURANCE (Secondary): _____

NAME: _____ RELATIONSHIP: _____

S.S. #: _____ INSURANCE ID# _____

DATE OF BIRTH: _____

EMPLOYER: _____ CITY: _____ ST: _____

PHYSICIAN NAME: _____

PHYSICIAN PHONE: _____

MEDICAL HISTORY – Certain illnesses and drugs may make it necessary to alter our treatment. In our endeavor to render the best possible oral health care to you. It is necessary to have the following information.

HAVE YOU EVER OR NOW HAVE *(Please check yes or no):*

Y	N		Y	N		Y	N	
☐	☐	Allergies to Medicine	☐	☐	Developmental Problems	☐	☐	Jaundice
☐	☐	Allergy to Penicillin	☐	☐	Diabetes	☐	☐	Kidney Disease
☐	☐	Anemia	☐	☐	Drug or Alcohol Abuse	☐	☐	Leukemia
☐	☐	Arthritis	☐	☐	Emotional Disturbance	☐	☐	Oral Ulcers
☐	☐	Asthma	☐	☐	Epilepsy	☐	☐	Orthopedic Problems
☐	☐	Bladder Conditions	☐	☐	Eye Problem	☐	☐	Pacemaker - Defibrillator
☐	☐	Blood Pressure Problems	☐	☐	Excessive Bleeding Problem	☐	☐	Pneumonia
☐	☐	Blood Transfusions	☐	☐	Fainting or Dizziness	☐	☐	Rheumatic Fever
☐	☐	Birth Defects	☐	☐	Frequent Infections	☐	☐	Scoliosis (Curved Spine)
☐	☐	Bone or Joint Problems	☐	☐	Hay Fever	☐	☐	Sickle Cell Anemia
☐	☐	Brain Injury	☐	☐	Hearing/Speech Problem	☐	☐	Sinus Problems
☐	☐	Bruising Easily	☐	☐	Heart Murmur/Heart Defects	☐	☐	Thyroid Problems
☐	☐	Cancer or Malignancies	☐	☐	Heart Surgery	☐	☐	Tuberculosis
☐	☐	Cerebral Palsy	☐	☐	Hemophilia	☐	☐	Ulcers/Stomach Problems
☐	☐	Chronic Headaches	☐	☐	Hepatitis or Liver Disease	☐	☐	Venereal Disease/Herpes
☐	☐	Cleft Lip/Palate	☐	☐	HIV Positive	☐	☐	Other _____
☐	☐	Convulsions/Seizures	☐	☐	Implants			_____

Do wounds heal slowly or present complications? ☐ Yes ☐ No

Presently taking medication? *(Please specify)* _____

Presently under a physician's care? ☐ Yes ☐ No

When was your last physical exam? _____

Have you ever been hospitalized? Date(s) _____ Reason(s) _____

Have you ever had x-ray treatment or chemotherapy? ☐ Yes ☐ No

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information I should be aware of that has not been covered: _____

(TURN OVER AND FILL OUT BACK TOP PORTION)

ADULT MEDICAL HISTORY

DATE OF LAST DENTAL EXAM: _____ DATE OF LAST FULL MOUTH X-RAY: _____ OFFICE TAKEN: _____

	YES	NO
1. Have you had trouble from previous dental care? When? Explain:		
2. Do you have pain in your jaw or near your ears?		
3. Do you have any unhealed injuries or inflamed areas in or around your mouth?		
4. Have you experienced any growths or sore spots in your mouth?		
5. Does any part of your mouth hurt when clenched?		
6. Have you ever had Novocaine or other local anesthetic?		
7. Have you ever had Nitrous Oxide (laughing gas)?		
8. Have you ever had general anesthesia?		
9. Have you ever had any reaction/allergic symptoms to Novocaine, local or general anesthetic?		
10. Have you ever had any difficult extractions in the past?		
11. Have you ever had prolonged bleeding following extractions in the past?		
12. Do your gums bleed?		
13. Do you have a bad taste in your mouth or mouth odor?		
14. Have you ever had instructions on the care of your gums?		
15. Do you chew on only one side of your mouth? If so why?		
16. Do you habitually clench or grind your teeth during the night or day?		
17. Is any part of your mouth sensitive to pressures or irritants. Where? Is it: Hot _____ Cold _____ Sweets _____ Sensitive?		

Is there any other problem not covered above that you would like to discuss? _____

Any personal requests you would like us to know about? _____

I acknowledge that the information above and on the reverse side is correct:

_____ _____ _____ _____

PATIENT SIGNATURE DATE DOCTOR SIGNATURE DATE

FUTURE RECALL MEDICAL HISTORY UPDATES

I have reviewed my MEDICAL HISTORY and my health status and medication ☐ Has NOT Changed ☐ Has Changed
Explain _____
PRINT NAME _____ SIGNATURE _____ DATE _____ DR. _____

I have reviewed my MEDICAL HISTORY and my health status and medication ☐ Has NOT Changed ☐ Has Changed
Explain _____
PRINT NAME _____ SIGNATURE _____ DATE _____ DR. _____

I have reviewed my MEDICAL HISTORY and my health status and medication ☐ Has NOT Changed ☐ Has Changed
Explain _____
PRINT NAME _____ SIGNATURE _____ DATE _____ DR. _____

I have reviewed my MEDICAL HISTORY and my health status and medication ☐ Has NOT Changed ☐ Has Changed
Explain _____
PRINT NAME _____ SIGNATURE _____ DATE _____ DR. _____

I have reviewed my MEDICAL HISTORY and my health status and medication ☐ Has NOT Changed ☐ Has Changed
Explain _____
PRINT NAME _____ SIGNATURE _____ DATE _____ DR. _____