BP: ____/____
Pulse: _____ Bpm

PATIENT MEDICAL/DENTAL HISTORY FORM

Name: _____
First *middle* *Last*

Address: _____
Street *(Apt/Unit #)* *City* *Postal Code*

Home: ( ) _____ **Mobile:** ( ) _____

D.O.B: / / **Email:** _____ ☐ Consent to receive email reminders.
DD MM YYYY

Emergency Contact: _____ Phone: ( ) _____

Health Card #: _____ **Family Physician:** _____ **Office:** _____

Who may we thank for referring you? _____

Do you have dental insurance?..... **Y N**

If you have dental insurance, please notify our receptionists and they will be happy to assist you!

Dental Anxiety: ***1 2 3 4 5 6 7 8 9 10*** *(Please circle--10 being high)*

Health History

Are you being treated for any medical condition or have you been treated within the past 2 years? ...... **Y N**

If YES, please describe: _____

Are you currently being treated by a physician for a specific condition? ..... **Y N**

If YES, please describe: _____

Are you currently taking any medication? ..... **Y N**

If yes please provide pharmacy list below:

Name of Pharmacy: _____

Name of Medication	Description of Diagnosis/Condition	Dosage

Do you bleed or bruise easily? ..... **Y N**

Have you ever received general anesthesia? ..... **Y N**

Have you ever had an adverse reaction to local anesthetic? ..... **Y N**

Do you have any allergies to medications? ..... **Y N**

If YES, please list: _____

Do you have any other allergies? ..... **Y N**

If YES, please list: _____

Please see the reverse side of this page; medical/dental history continued....

PATIENT MEDICAL/DENTAL HISTORY FORM

Have you ever had or currently have any of the following? *(Please check boxes that apply to you)*

Heart Murmur ☐	Osteoporosis ☐	Hearing Impairment ☐	Rheumatic Fever ☐
Heart Valve Replacement ☐	Asthma ☐	COPD ☐	Sleep Apnea ☐
Artificial Joint Replacement ☐	Hepatitis A/B/C/D ☐	Thyroid Disease ☐	Mental Illness ☐
Diabetes Type 1 / Type2 ☐	AIDS/HIV ☐	Herpes / Cold Sores ☐	High Blood Pressure ☐
Heart Attack ☐	Angina ☐	Glaucoma ☐	Hernia ☐ When? _____
Atherosclerosis ☐	Stroke ☐	Cataract Surgery ☐	
Kidney Disease ☐	Liver Disease ☐	Drug/Alcohol Abuse ☐	Vitreoretinal Surgery ☐ (When? _____)
Cancer ☐ (Type_____)	Jaundice ☐	ADHD ☐	Hormone Replacement Therapy ☐
Epilepsy ☐	Pacemaker ☐	Organ Transplant ☐	Arthritis ☐ (Type_____)
Radiation Therapy ☐	Steroid Therapy ☐	Stress ☐	Surgery to Head and Neck ☐
Lupus ☐	Fainting/Dizzy Spells ☐	Sinus Trouble ☐	Fibromyalgia ☐

Has the CHILD PATIENT recently had any of the following? *(Please check boxes that apply)*

Measles ☐	Mumps ☐	Strep Throat ☐	Tonsillitis ☐
Chicken Pox ☐	Croup ☐	Bronchitis ☐	

Is there anything else the dentist needs to know regarding your medical health? ..... **Y N**

If YES, please explain: _____

Do you smoke cigarettes and/or cigars? *(Please circle)* **Y N Quit Chew Tobacco?** ..... **Y N**

Amount/day: _____ for how long? _____ Quit Date: _____

Dental History

Are you currently experiencing any pain or discomfort? ..... **Y N**

Please check if any of your teeth sensitive to: ___ Cold ___ Hot ___Sweet ___Pressure ___ N/A

If Yes, which teeth or areas? _____

Do you have difficulty chewing food? ..... **Y N**

Are you happy with the overall appearance/function of your teeth? ..... **Y N**

Have you ever had braces for straightening your teeth? ..... **Y N**

Have you ever had an injury to your jaw or face? ..... **Y N**

PATIENT GENERAL RELEASE CONSENT

I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical-dental history. Should there be any change in either my health status or any other information I have provided, I will advise. I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my medical doctor or another health care provider may be necessary. I have been advised of the privacy policy of the office and that my personal information will be collected, used and disclosed within the guidelines of the policy. I understand that responsibility for payment of the dental services for myself and my dependents is mine, and I assume responsibility for fees associated with these services. I am aware that 2 business days' notice is required to change or cancel an appointment without charge. I provide consent for the office to send dental claims electronically to my insurance company.

_____ _____

SIGNATURE **Patient** ☐ **Parent** ☐ **Guardian** ☐ **DATE**

_____ _____

DENTIST'S SIGNATURE **DATE**