

# Welcome

## PATIENT MEDICAL HISTORY

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATION THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

DATE \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ SSN \_\_\_\_\_

NAME \_\_\_\_\_ SEX M  F

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ CELL \_\_\_\_\_

EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

PARENT/GUARDIAN'S NAME \_\_\_\_\_ EMPLOYER \_\_\_\_\_

PERSON TO CONTACT IN CASE OF EMERGENCY \_\_\_\_\_ PHONE \_\_\_\_\_

REFERRING DENTIST \_\_\_\_\_

PHYSICIAN \_\_\_\_\_

OFFICE PHONE \_\_\_\_\_

PLEASE LIST HOSPITALIZATION FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS WITHIN THE LAST 5 YEARS.  
\_\_\_\_\_  
\_\_\_\_\_

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

	YES	NO
HEART DISEASE .....	<input type="checkbox"/>	<input type="checkbox"/>
MITRAL VALVE PROLAPSE .....	<input type="checkbox"/>	<input type="checkbox"/>
HEART MURMUR .....	<input type="checkbox"/>	<input type="checkbox"/>
RHEUMATIC FEVER .....	<input type="checkbox"/>	<input type="checkbox"/>
HEART ATTACK (DATE _____) .....	<input type="checkbox"/>	<input type="checkbox"/>
STROKE (DATE _____) .....	<input type="checkbox"/>	<input type="checkbox"/>
CARDIAC PACEMAKER .....	<input type="checkbox"/>	<input type="checkbox"/>
JOINT REPLACEMENT OR IMPLANT (DATE _____) .....	<input type="checkbox"/>	<input type="checkbox"/>
HEPATITIS / JAUNDICE .....	<input type="checkbox"/>	<input type="checkbox"/>
HIGH BLOOD PRESSURE .....	<input type="checkbox"/>	<input type="checkbox"/>
TUBERCULOSIS .....	<input type="checkbox"/>	<input type="checkbox"/>
DIABETES .....	<input type="checkbox"/>	<input type="checkbox"/>
KIDNEY DISEASES .....	<input type="checkbox"/>	<input type="checkbox"/>
EPILEPSY / CONVULSIONS .....	<input type="checkbox"/>	<input type="checkbox"/>
SEXUALLY TRANSMITTED DISEASE .....	<input type="checkbox"/>	<input type="checkbox"/>
AIDS OR HIV INFECTION .....	<input type="checkbox"/>	<input type="checkbox"/>
LEUKEMIA .....	<input type="checkbox"/>	<input type="checkbox"/>
EMPHYSEMA .....	<input type="checkbox"/>	<input type="checkbox"/>
ASTHMA .....	<input type="checkbox"/>	<input type="checkbox"/>
CANCER .....	<input type="checkbox"/>	<input type="checkbox"/>
OTHER .....	<input type="checkbox"/>	<input type="checkbox"/>

ARE YOU ALLERGIC TO OR HAVE YOU HAD ANY REACTIONS TO THE FOLLOWING?

	YES	NO
LOCAL ANESTHETICS (E.G. NOVOCAINE) .....	<input type="checkbox"/>	<input type="checkbox"/>
PENICILLIN OR ANY OTHER ANTIBIOTICS .....	<input type="checkbox"/>	<input type="checkbox"/>
SULFA DRUGS .....	<input type="checkbox"/>	<input type="checkbox"/>
BARBITURATES .....	<input type="checkbox"/>	<input type="checkbox"/>
SEDATIVES .....	<input type="checkbox"/>	<input type="checkbox"/>
IODINE .....	<input type="checkbox"/>	<input type="checkbox"/>
ASPIRIN .....	<input type="checkbox"/>	<input type="checkbox"/>
ANY METALS (E.G. NICKEL, MERCURY, ETC.) .....	<input type="checkbox"/>	<input type="checkbox"/>
LATEX RUBBER .....	<input type="checkbox"/>	<input type="checkbox"/>
OTHER (PLEASE LIST) _____	<input type="checkbox"/>	<input type="checkbox"/>
ARE YOU TAKING ANY MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE? IF YES, WHAT MEDICATION(S) ARE YOU TAKING?	<input type="checkbox"/>	<input type="checkbox"/>
_____		
_____		
_____		

OVER →

DO YOU USE TOBACCO? (smoking, snuff, chew) YES NO  
IF YES, HOW INTERESTED ARE YOU IN STOPPING?    
(CIRCLE ONE) VERY / SOMEWHAT / NOT INTERESTED

WOMEN ONLY:  
a) ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT? .....  YES  NO  
b) ARE YOU NURSING? .....    
c) ARE YOU TAKING ORAL CONTRACEPTIVES?

### AUTHORIZATION AND RELEASE

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 AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

X \_\_\_\_\_ DATE \_\_\_\_\_  
SIGNATURE OF PATIENT (OR PARENT/GUARDIAN IF MINOR)

DOCTOR'S COMMENTS _____ _____ SIGNATURE _____ DATE _____
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### ANNUAL UPDATES

DATE: \_\_\_\_\_  
MEDICATIONS: \_\_\_\_\_  
\_\_\_\_\_  
HOSPITALIZATIONS/SURGERY: \_\_\_\_\_  
\_\_\_\_\_  
ADDRESS/PHONE: \_\_\_\_\_  
\_\_\_\_\_  
STAFF INITIALS: \_\_\_\_\_

DATE: \_\_\_\_\_  
MEDICATIONS: \_\_\_\_\_  
\_\_\_\_\_  
HOSPITALIZATIONS/SURGERY: \_\_\_\_\_  
\_\_\_\_\_  
ADDRESS/PHONE: \_\_\_\_\_  
\_\_\_\_\_  
STAFF INITIALS: \_\_\_\_\_

DATE: \_\_\_\_\_  
MEDICATIONS: \_\_\_\_\_  
\_\_\_\_\_  
HOSPITALIZATIONS/SURGERY: \_\_\_\_\_  
\_\_\_\_\_  
ADDRESS/PHONE: \_\_\_\_\_  
\_\_\_\_\_  
STAFF INITIALS: \_\_\_\_\_

DATE: \_\_\_\_\_  
MEDICATIONS: \_\_\_\_\_  
\_\_\_\_\_  
HOSPITALIZATIONS/SURGERY: \_\_\_\_\_  
\_\_\_\_\_  
ADDRESS/PHONE: \_\_\_\_\_  
\_\_\_\_\_  
STAFF INITIALS: \_\_\_\_\_