MEDICAL HISTORY

PATIENT NAME____________________________ DATE OF BIRTH________
ADDRESS____
TOWN_____________________ZIP CODE_________________________________
MARITAL STATUS_____________ CELL PHONE________________________
HOME PHONE____________________ WORK PHONE____________________
EMAIL ADDRESS____
OCCUPATION____

DO YOU HAVE OR HAVE YOU HAD:

ABNORMAL BLEEDING________
AIDS OR HIV________________
ARTIFICIAL HEART VALVES____
ARTIFICIAL JOINT OR PROTHESIS___________
BLOOD TRANSFUSION_________
CANCER____________________
CHEMICAL DEPENDENCY______

CHEMO THERAPY________
DIABETES_____________
EPILEPSY OR SEIZURES________
HEART DISEASE_________
RADIATION TX________
HEPATITIS_____________

HIGH BLOOD PRESSURE________
LIVER PROBLEMS_____
PACEMAKER_________
PSYCHIATRIC CARE___
TOBACCO HISTORY_________

NOTES:____

____

ALLERGIES:

ANTIBIOTICS________
ANESTHETICS_______

CODEINE_____
LATEX______

PENICILLIN______
OTHER__________

CURRENT MEDICATIONS____

WHAT PROMPTED YOU TO COME AND SEE US?______________________________

WHAT IS YOUR PRIMARY DENTAL HEALTH CONCERN?_______________________

HOW WOULD YOU RATE YOUR DENTAL HEALTH ON A SCALE 0-10?___________

HOW WOULD YOU RATE THE APPEARANCE OF YOUR SMILE ON A SCALE OF 0-10?_____

DO YOU EXPERIENCE TOOTH SENSITIVITY?______________________________

DO YOUR GUMS BLEED OR HURT?_______________________________________

HAVE YOU EVER HAD ORTHODONTIC TREATMENT (BRACES)?__________________

HAVE YOU EVER WORN A NIGHTGUARD OR APPLIANCE?______________________

HAVE YOU EVER SEEN A PERIODONTIST?__________________________________

DO YOU HEAR CLICKING OR POPPING WHEN YOU OPEN OR CLOSE YOUR MOUTH?____

DOES YOUR JAW GET TIRED WHEN YOU TALK OR EAT?______________________

DO YOU GET HEADACHES?____

DO YOU FEEL NERVOUS ABOUT HAVING DENTAL TREATMENT?
YES NO IF YES, WHAT IS YOUR BIGGEST CONCERN?_______________________

WHAT IS MOST IMPORTANT TO YOU IN A DENTAL PRACTICE?________________

IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW?__________________

Whom may we thank for referring you to our practice?______________________________

I acknowledge to you that I have been given the opportunity to ask questions about the examination, the procedures to be used and the risks involved however slight. I believe that I have sufficient information to give you my consent.
I also give you permission to share my health information with other health care professionals and dental specialists. This includes the release of my dental charts and records for the sole purpose of consultation regarding diagnosis, treatment planning and care.
Further, I give you permission to use my photographs for educational and marketing purposes.

PAYMENT AGREEMENT

With my signature below, I understand that I am fully responsible for all fees associated with my dental care, and that all fees are due at the time of service.

______________________________ ______________
SIGNATURE DATE