ADULT MEDICAL & DENTAL HISTORY FORM

First Name _____ **MI**_____ **Last Name**_____ **DOB** _____
Today's date _____

MEDICAL HISTORY

Physician's Name _____ **Phone # (if available)** _____ **Approx. date of last visit**_____

1. Are you under medical treatment now?	**Y**	**N**
2. Have you ever been hospitalized for any surgical procedure or serious illness?	**Y**	**N**
3. Are you taking any prescription or non-prescription medications?	**Y**	**N**
4. Do you require a prophylactic antibiotic before dental appointments?	**Y**	**N**
5. Do you use tobacco?	**Y**	**N**

6. Are you allergic to an y of the following?

_____**Local Anesthetics (Novocaine)**	_____**Sedatives**	_____**Seasonal**
_____**Penicillin or Amoxicillin**	_____**Pain Killers**	_____**Any Foods**
_____**Other Antibiotics**	_____**Aspirin**	_____**Latex**
_____**Any Metals**	_____**Sulfa Drugs**	_____**Other**_____

7. Women: Are you pregnant or think you may become pregnant?	**Y**	**N**
Are you nursing?	**Y**	**N**
Are you taking birth control pills?	**Y**	**N**

Have you had any history or ever been diagnosed with any of the following (mark all that apply):

_____AIDS/HIV Positive	_____Cortisone Medication	_____Hemophilia	_____Renal Dialysis
_____Alzheimer's Disease	_____Diabetes	_____Hepatitis A	_____Rheumatic Fever
_____Anaphylaxis	_____Drug/Alcohol Addiction	_____Hepatitis B or C	_____Rheumatism
_____Anemia	_____Easily Winded	_____Herpes	_____Scarlet Fever
_____Angina	_____Emphysema	_____High Blood Pressure	_____Shingles
_____Arthritis/Gout	_____Epilepsy or Seizures	_____Hives or Rash	_____Sickle Cell Disease
_____Artificial Heart Valve	_____Excessive Bleeding	_____Hypoglycemia	_____Sinus Trouble
_____Artificial Joint	_____Excessive Thirst	_____Irregular Heartbeat	_____Sleep Apnea
_____Asthma	_____Fainting Spells/Dizziness	_____Kidney Problems	_____Stomach/Intestinal Problems
_____Blood Disorder	_____Frequent Cough	_____Leukemia	_____Stroke
_____Blood Transfusion	_____Frequent Diarrhea	_____Liver Disease	_____Swelling of Limbs
_____Breathing Problem	_____Frequent Headaches	_____Low Blood Pressure	_____Thyroid Disease
_____Bruise Easily	_____Genital Herpes	_____Lung Disease	_____Tonsillitis
_____Cancer	_____Glaucoma	_____Mitral Valve Prolapse	_____Tuberculosis
_____Chemotherapy	_____Hay Fever	_____Pain in Jaw Joints	_____Tumors or Growths
_____Chest Pains	_____Heart Attack/Failure	_____Parathyroid Disease	_____Ulcers
_____Cold Sores	_____Heart Murmur	_____Psychiatric Care	_____Venereal Disease
_____Congenital Heart Defect	_____Heart Pace Maker	_____Radiation Treatments	_____Yellow Jaundice
_____Convulsions	_____Heart Trouble/Disease	_____Recent Weight Loss	_____Other_____

Please list any medications you are currently taking (prescription, over-the-counter, herbal)

_____ _____ _____
_____ _____ _____

Comments:
_____

DENTAL HISTORY

Name of previous dentist: _____ **Approximate date of your last dental visit :** _____

What was done at this visit? (Cleaning & Exam, Fillings, etc.): _____

How often do you brush?: _____ **How often do you floss?**_____

Do your gums bleed while flossing?	**Y**	**N**
Are your teeth sensitive to hot or cold liquids/foods	**Y**	**N**
Are your teeth sensitive to sweets?	**Y**	**N**
Do you feel any pain associated with your teeth or mouth?	**Y**	**N**
Do you have any sores or lumps in or near your mouth?	**Y**	**N**
Have you ever had any head, neck, or jaw injuries?	**Y**	**N**
Have you ever had any problems with your jaw joints?		
Clicking or popping?	**Y**	**N**
Pain or soreness (joint, ear, or side of face)?	**Y**	**N**
Difficulty opening or closing?	**Y**	**N**
Difficulty chewing?	**Y**	**N**

Do you have frequent headaches?	**Y**	**N**
Do you clench or grind your teeth?	**Y**	**N**
Are your jaws tired when you wake up in the morning?	**Y**	**N**
Have you ever had difficult extractions in the past?	**Y**	**N**
Have you ever had any orthodontic work?	**Y**	**N**
Do you frequently have a dry mouth?	**Y**	**N**
Are you interested in any kind of cosmetic treatment?	**Y**	**N**

Specify (whitening, veneers, straightening, etc.) _____

Comments: _____

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 doctor 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 medical care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the doctor or doctor group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or my dependent.

Patient Signature: _____ **Date**_____