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MEDICAL-DENTAL HISTORY

PATIENT'S NAME: ______________________________ DATE OF BIRTH:____________ AGE:__________

SOCIAL SECURITY #:_______________________ SEX OF PATIENT: MALE/FEMALE

MEDICAL HISTORY

Please indicate date if you have ever had:

Yes	NO		Yes	NO	
		Alcoholism			HIV/AIDS
		Allergies			Implants/joints
		Anemia			Jaundice/liver disease
		Arthritis			Kidney disease
		Asthma			Low blood pressure
		Bisphosphnates			Measles/Mumps
		Bleeding/bruising			Paralysis
		Blood transfusion			Psychiatric treatment
		Cancer			Radiation treatment
		Chemotherapy			Rheumatic fever/ Scarlet fever
		Chickenpox			Seizures
		Convulsions			Sexually transmissible infections
		Diabetes			Steroid therapy
		Difficulty hearing			Stroke
		Drug dependency			Surgery
		Emphysema			Thyroid disease
		Epilepsy			Tuberculosis
		Fainting			Tumor
		Frequent headaches			Ulcers
		Heart attack			Vision changes
		Heart disease			Do you use tobacco?
		Heart murmur			Do you use street drugs?
		Heart surgery			Do you have an allergy to latex or vinyl?
		Hepatitis A/B/C			Are you pregnant? How many weeks?
		High blood pressure			Do you think you may be pregnant?

Have you ever experienced an unusual or allergic reaction to any of the following drugs:

YES	NO		YES	NO		YES	NO	
		Aspirin			Local anesthetic			Sulfa drugs
		Barbiturates			Narcotics			Other:
		Codeine			Penicillin			
		Iodine			Sleeping pills			

If you've had a reaction, what happens to you?:____

Please list any medications you are currently taking:____

dental aid
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MEDICAL-DENTAL HISTORY

DENTAL HISTORY

Please check if you NOW have:

Yes	NO		Yes	NO	
		Bleeding gums			Pain or ringing in your ears
		Loosened teeth			Popping/clicking of your jaw when opening wide
		Gum surgery or gum treatment			Slow healing sores in mouth or on lips
		A habit of clenching or grinding Your teeth			Tiredness in your face/jaws when you awake
		Difficulty opening your mouth wide			Complications following dental treatment, if so, please explain
		A habit of breathing through your mouth			

Are you now in pain due to a dental problem? YES/NO
If yes, how long have you been in pain?________________________________
What have you done to decrease the pain?________________________________
Date of last dental visit:____________________ Date of last dental x-rays: ____________________
Name and location of last dentist:________________________________
Do you wear dentures or partials? YES/NO If yes, how old are they?________________________________
Explain the reason you are seeking dental care at our office today________________________________
Have you lost or gained weight in recent months? YES/NO If yes, please explain____________________
Do you have a family physician? YES/NO If yes, name and location:________________________________
May we contact your doctor for consultation? YES/NO If yes, please sign and date in this space:
____
Do you fear receiving dental care? YES/NO
How important to you is the way your teeth look? __Very important __ Somewhat important ___Unimportant

INSURANCE INFOMRATION

Medicaid: YES/NO Medicaid Number: ________________________________
CHP+: YES/NO Plan Number:________________________________
Delta Dental: YES/NO Plan Number: ____________________ ID #:____________________
Other Insurance: YES/NO Plan Number: ____________________ ID#: ____________________
Insurance Company Name and Address:________________________________

____
Patient Signature Date

____
Dentist Signature Date

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