

MEDICAL DENTAL HISTORY FORM - ADULT



Please fill out the form below

MEDICAL/DENTAL HISTORY FORM - ADULT

Last Name <input type="text"/>		Initial <input type="text"/>	First Name <input type="text"/>
Address <input type="text"/>		City <input type="text"/>	Postal <input type="text"/>
Home Tel <input type="text"/>	Cell <input type="text"/>	Work <input type="text"/>	
Date of Birth: DD/MM/YYYY <input type="text"/>		Email Address <input type="text"/>	
Emergency Contact <input type="text"/>		Phone <input type="text"/>	
How did you hear about us? <input type="text"/>		Health Card # <input type="text"/>	

Do you have dental insurance? Yes No **If Yes complete the following**

Primary Insurance

Company <input type="text"/>	Policy Holder <input type="text"/>
Policy/Plan/Group <input type="text"/>	Certificate/I.D. <input type="text"/>
Policy holders Date of Birth DD/MM/YYYY <input type="text"/>	Relation to Holder <input type="text"/>

Secondary Insurance

Company <input type="text"/>	Policy Holder <input type="text"/>
Policy/Plan/Group <input type="text"/>	Certificate/I.D. <input type="text"/>
Policy holders Date of Birth DD/MM/YYYY <input type="text"/>	Relation to Holder <input type="text"/>

Has there been any change in your general health? Yes No

If YES please describe

Are you being treated for any medical condition or have you been treated within the past 2 years? Yes No

If YES please describe

Are you currently being treated by a physician for a specific condition? Yes No

If YES please describe

Are you currently taking any medication? Yes No

Medication <input type="text"/>	Dose <input type="text"/>
Medication <input type="text"/>	Dose <input type="text"/>
Medication <input type="text"/>	Dose <input type="text"/>

Do you bleed or bruise easily? Yes No

Have you ever been hospitalized? Yes No

If YES please describe

Have you ever received general anesthesia? Yes No

Have you ever had an adverse reaction to local anesthetic? Yes No

Do you have any allergies to medications? Yes No

If YES please describe

Do you have any other allergies?

Yes No

If YES please list

Do you currently have any of the following conditions?

- | | | | | | |
|---------------------------------------------|--------------------------------------------|------------------------------------------|--------------------------------------------------|---------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Osteopenia | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Asthma | <input type="checkbox"/> COPD |
| <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Hepatitis A/B/C/D | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Herpes / Cold Sores |
| <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Angina | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Atherosclerosis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> ADHD | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Organ Transplant | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Radiation Therapy | <input type="checkbox"/> Steroid Therapy | <input type="checkbox"/> Stress | <input type="checkbox"/> Diabetes Type 1 / Type2 | <input type="checkbox"/> Steroid Therapy | <input type="checkbox"/> Surgery to Head and Neck |

Is there anything else the doctor needs to know regarding your medical health? Yes No

If YES please explain

Do you smoke? Yes No Quit Tobacco Cigars Chew Other

Amount/day <input type="text"/>	for how long? <input type="text"/>	Quit Date <input type="text"/>
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Females ONLY

Are you or could you be pregnant? Yes No

Are you currently breast-feeding? Yes No

Dental History

Are you currently experiencing any pain or discomfort? Yes No

Are any of your teeth sensitive to Cold Hot Sweet Biting

Do you have difficulty chewing food or does food get stuck between your teeth? Yes No

Are you unhappy with the overall appearance of your teeth? Yes No

Have you ever had braces for straightening your teeth? Yes No

Have you ever had an injury to your jaw or face? Yes No

Does your jaw ever click or pop or cause pain upon opening or closing? Yes No

Are you nervous during dental treatment? Yes No

Reason

PATIENT CERTIFICATION AND CONSENT

I the undersigned, certify that all the above medical and dental information is true to the best of my knowledge and that I have not omitted any pertinent information. I agree to the performing of dental and oral surgery procedures with these procedures. I agree to the privacy policies used in the reception area and consent to the electronic sharing of information with my insurance company for the purpose of processing insurance claims and determination of benefits. Unless other arrangements have been made assignment of benefits from your insurance company will be set up. My dental insurance plan is a contract between myself and my insurance company, not between my insurance company and my dentist. I authorize the dentist to treat me and I assume full responsibility for all fees. I am aware that 2 business days notice is required to change or cancel an appointment without charge.

SIGNATURE (PARENT OR GUARDIAN IF UNDER 16)

To be signed at your appointment