4 Medical History cont.

Do you have any metal rods, pins or implants? ☐ Y ☐ N

WOMEN: Are you using a prescribed method of birth control? ☐ Y ☐ N

Are you pregnant? ☐ Y ☐ N Week #:_____

Are you nursing? ☐ Y ☐ N

Have you ever had any of the following diseases or medical problems?

Y N	Abnormal Bleeding	Y N	Hepatitis
Y N	Alcohol / Drug Abuse	Y N	Herpes / Fever Blisters
Y N	Anemia	Y N	High / Low Blood Pressure
Y N	Arthritis	Y N	HIV+ / AIDS
Y N	Artificial Bones / Joints / Valves	Y N	Hospitalized for Any Reason
Y N	Asthma	Y N	Kidney Problems
Y N	Blood Transfusion	Y N	Liver Disease
Y N	Cancer / Chemotherapy	Y N	Lupus
Y N	Congenital Heart Defect	Y N	Mitral Valve Prolapse
Y N	Diabetes	Y N	Osteoporosis / Paget's Disease
Y N	Difficulty Breathing	Y N	Psychiatric Problems
Y N	Emphysema	Y N	Radiation Treatment
Y N	Epilepsy / Seizures / Fainting	Y N	Rheumatic / Scarlet Fever
Y N	Frequent Headaches	Y N	Shingles
Y N	Glaucoma	Y N	Sickle Cell Disease / Traits
Y N	Hay Fever	Y N	Sinus Problems
Y N	Heart Attack / Stroke	Y N	Thyroid Problems
Y N	Heart Murmur	Y N	Tuberculosis (TB)
Y N	Heart Surgery / Pacemaker	Y N	Ulcers / Colitis
Y N	Hemophilia	Y N	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

Y N	Aspirin	Y N	Dental Anesthetics	Y N	Penicillin
Y N	Codeine	Y N	Erythromycin	Y N	Tetracycline
Y N	Metals / Plastics	Y N	Latex	Y N	Other

List any other drug / material allergies: _____

_____ _____

5 Dental History

What concerns brought you to the dentist today?

_____

Do you require antibiotics before dental treatment? ☐ Y ☐ N

Are you currently in pain? ☐ Y ☐ N

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Y ☐ N

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Y ☐ N

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Y ☐ N Do your gums bleed? ☐ Y ☐ N

How many times a week do you floss? _____ a day do you brush? _____

Type of bristles you use: ☐ Soft ☐ Medium ☐ Hard

How often do you replace your toothbrush? _____

Are your teeth sensitive to heat, cold or anything else? _____

Have you lost any teeth? ☐ Y ☐ N If yes, why? _____

_____

6

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

_____

SIGNATURE DATE

Financial Policy

Payment is due at or before time of service. If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to this office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize any release of information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____

SIGNATURE DATE

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials: _____ Date: _____

Doctor's Comments: _____

_____

Medical History Update

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____

SIGNATURE DATE

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____

SIGNATURE DATE