Medical History

Patient's name: Date of birth:

If you are completing this form for another person:

Your name: Phone: Relationship:

Primary and specialty physicians:

Name: Phone: City and state:

Date of last physical examination:

Have you been hospitalized in the past three years? ☐Yes or ☐No

If yes, please give reason and date:

Current treatment you are undergoing:

Have you ever been instructed to take ANY medication or special precautions prior to dental treatment? If Yes, please explain:

Do you take any medications (prescribed, over-the-counter) or vitamins?

If yes, please list:

Do you have any allergies? ☐Yes or ☐No

If yes, please list:

Do you have or have you ever had any of the following (please check all that apply)

☐Congenital heart defects	☐Angina	☐Atherosclerosis
☐Congestive heart failure	☐Coronary artery disease	☐Heart surgery, date:
☐Rheumatic fever	☐Heart murmur	☐Heart attack, date:
☐Heart valve(s) damage	☐Artificial heart valve	☐Pacemaker
☐Mitral valve prolapse	☐Stroke	☐Anemia
☐Bleeding disorder	☐Excessive bleeding if cut	☐Diabetes
☐Artificial joints/Prosthesis	☐Hepatitis	☐Cancer
If yes, joint:	☐Asthma	☐Sinusitis
Date:	☐Tuberculosis	☐Thyroid problems
☐Arthritis	☐Glaucoma	☐Epilepsy
☐Kidney problems	☐Ulcers, acid reflux	☐Mental health care
☐Active STD (sexually-transmitted disease	☐Compromised immune system (Lupus, HIV AIDS, radiation illnesses)	☐ Hypertension ☐Other:

Women:

Are you taking hormone replacement therapy? ☐Yes or ☐No

Are you using birth control medication? ☐Yes or ☐No

If pregnant, what is your due date:

Are you breastfeeding? ☐Yes or ☐No

Oral health risk factors:

Do you or have you ever smoked or used smokeless tobacco regularly? ☐Yes ☐No

If yes, how much did you smoke or use smokeless tobacco?

How many years did you smoke or use smokeless tobacco?

If you quit, when did you quit?

Dental and Oral Health Information

Are there any specific dental problems that you would like the doctor to address?

How long has it been present?

Are there any dental cosmetics you are interested in?

How do you rate your overall dental health? ☐Good ☐Fair ☐Poor

How many times a day do you brush your teeth? ☐0 ☐1 ☐2 ☐3 ☐4 ☐>4

How many times a week do you floss? ☐0 ☐1 ☐2 ☐3 ☐4 ☐>4

Payment-Payment is expected when treatment is rendered, unless other arrangements are made in advance. A service charge of 1.5% per month will be added to unpaid balance of all accounts over 30 days. In the event we must hire an attorney or collection agency to collect this debt, you will be responsible for the payment of all costs and expenses including court costs and reasonable attorney's fees. A minimum charge of $25.00 will be made for failed or cancelled appointments without prior notification of at least 24 hours.

Insurance-For your convenience, we will complete any forms required by you dental insurance company. Your signature authorizes the release of any information regarding your dental claims to your insurance carrier(s). It also authorizes payment directly to our office. It is your responsibility, however, to cover the balance of treatment cost, or to cover the entire cost if your insurance should fail to provide coverage. We do not render our services on the basis that insurance will pay all our charges. Each fee is separate for that individual patient.

Appointment confirmation: The office may send appointment reminders and/or phone confirmation calls for prophylaxis appointments.

Signature of patient: See digital signature below Date: Attached to digital signature.
(Guardian if patient is a minor)

Signature of person responsible for account: _____

Dentist's signature: _____