Susanne M. Sanford D.D.S.

971 E. Sherman Blvd. • Muskegon, MI 49444

frontdesk@ssanforddds.com
(231)733-5540

Medical & Dental History Form

Patient Name: ______________________ * ______________________ * ____ ______________

Last First MI Preferred Name

Emergency Contact: Name and Phone Number (must list at least one)

____

____

Within the past year, have there been any changes in your general health? ◯ Yes ◯ No

What is your Primary Care Physicians name & phone number? What is the date (or approximate date) of your last medical exam? *

____

____

Are you currently under the care of a physician due to a specific condition? ◯ Yes ◯ No

Have you ever been hospitalized within the last 5 years due to surgery or illness? ◯ Yes ◯ No

If any of the previous questions are marked, please explain: *

____

____

WOMEN ONLY: Are you currently pregnant? * ◯ Yes ◯ No

What MEDICATIONS or other SUBSTANCES are you taking or have you taken in the past 2 months?
Please list all PRESCRIPTION and NON-PRESCRIPTION drugs including aspirin, birth control pills, herbal medication or other supplements. Write "none" if you are not taking any medications or substances.

____

____

____

____

____

Have you taken or are you taking drugs to control bone lose? (ie. Fosomax) ◯ Yes ◯ No

Sleep Apnea? *

☐ Snore ☐ Use Cpap Machine

Do you smoke? *

☐ Cigarettes ☐ E-Cigarettes ☐ Vaping ☐ Cigar/Pipe ☐ Chewing Tobacco

Do you use nicotine and/or marijuana?

- [ ] Cigarettes
- [ ] E-Cigarettes
- [ ] Vaping
- [ ] Cigar/Pipe
- [ ] Chewing Tobacco
- [ ] Marijuana (medicinal)
- [ ] Marijuana (recreational)

Other

____

____

Please indicate if you have experienced any of the following:

Breathing problems?

- [ ] Asthma
- [ ] COPD
- [ ] Emphysema
- [ ] Tuberculosis
- [ ] Shortness of breath
- [ ] Other breathing problems-explain

Other breathing problems-explain

____

____

Heart or circulation problems?

- [ ] Pre-Medication-antibiotic for heart condition
- [ ] Heart valve damage or replacement
- [ ] Heart attack
- [ ] Blood thinners
- [ ] High blood pressure
- [ ] Angina or chest pain
- [ ] Irregular heart beat
- [ ] Congestive heart failure
- [ ] High Cholesterol
- [ ] Pacemaker

Other heart or circulation problems-explain

____

____

Kidney or urinary problems?

- [ ] Kidney disease
- [ ] Dialysis

Other kidney problems-explain

____

____

Nervous system problems?

- [ ] Anxiety
- [ ] Depression
- [ ] Stroke or transitory ischemic attack
- [ ] Fainting spells
- [ ] Mental Health
- [ ] Seizures or epilespy
- [ ] Vertigo

Other nervous system problems-explain

____

____

Head and neck problems?

- [ ] Nose or sinus problems
- [ ] Swollen glands
- [ ] Oral cancer
- [ ] Impairment of hearing, sight or speech?
- [ ] Frequent or severe headaches /migraines

Hormone or gland problems?

- [ ] Thyroid disease (hypothyroidism, hyperthyroidism)
- [ ] Diabetes
- [ ] Adrenal or pancreatic disease

Other hormone/gland disease-explain

____

____

Muscle, bone or skin problems?

- [ ] Artificial joint replacement
- [ ] Pre-Medication-antibiotic for artificial joint replacement
- [ ] Arthritis
- [ ] Osteoporosis
- [ ] Skin cancer
- [ ] Back problems

Other muscle, bone or skin disease-explain

____

____

Stomach, liver, intestinal problems?

- [ ] Liver disease
- [ ] Hepatitis
- [ ] Acid reflux (GERD)
- [ ] Ulcers

Other stomach, intestinal or liver problems-explain

____

____

Allergic reactions or other problems?

- [ ] Seasonal allergies
- [ ] Penicillin
- [ ] Erthromycin
- [ ] Codeine
- [ ] Local anesthetics
- [ ] Foods/flavoring

Other substances- explain

____

____

Blood or auto immune system problems?

- [ ] Cancer of any type
- [ ] Chemotherapy
- [ ] Radiation treatment
- [ ] Organ or bone marrow transplant
- [ ] Lupus
- [ ] Mutiple sclerosis
- [ ] Anemia
- [ ] Hemophilia
- [ ] AIDS/HIV
- [ ] Frequent nosebleeds, increased bruising or bleeding

Other problems with the blood or auto immune system-explain

____

____

What is the reason for your dental visit today?

____

____

When was your last visit to the dentist (if to a different office)? Who did you go to?

____

____

Please list any other parties who can have access to your health information: (This includes step-parents, grandparents and any other care givers who can have access to this patient's health information):

Name/Relationship:

____

____

☐ **To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.**

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and payment is due on the day services are rendered. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian:

Signature ____ **Date** ____________

Relationship to Patient:

____

____

Response Date: ____________