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Medical & Dental History Form				
Patient Name:*		•		
Last	First	MI	Preferred Name	
Emergency Contact: Name and Phone Number (must list at leas	st one)			
		·		
Within the past year, have there been any changes in your gene	aral health? 🔿 Yes 🔿 No			
What is your Primary Care Physicians name & phone number? \	What is the date (or approximate	e date) of your last	t medical exam? *	
Are you currently under the care of a physician due to a specific	c condition? () Yes () No			
Have you ever been hospitalized within the last 5 years due to s	surgery or illness? () Yes () N	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 hav Please list all PRESCRIPTION and NON-PRESCRIPTION drugs inc "none" if you are not taking any medications or substances.			n or other supplements. Write	

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

Sleep Apnea? *

Snore Snore

Use Cpap Machine

Do you smoke? *

Cigarettes

E-Cigarettes Vaping

Cigar/Pipe

Chewing Tobacco

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Do you use nicotine and/	or marijuana?		_	
Cigarettes	E-Cigarettes	Vaping	Cigar/Pipe	Chewing Tobacco
Marijuana (medicinal)	🔛 Marijuana (recre	ational)		
Other				
Please indicate if you ha	ave experienced any (of the following:		
Breathing problems?				
Asthma		C	Emphysema	Tuberculosis
Shortness of breath		reathing problems-explain		
Other breathing problem	ns-explain			
Heart or circulation prot		Heart valve damage or re		Heart attack
Pre-Medication-antibioti	ic for heart condition		· <u> </u>	Angina or chest pain
Blood thinners		High blood pressure	_	
Irregular heart beat		Congestive heart failure		High Cholesterol
Pacemaker				
Other heart or circulation	on problems-explain			
ler e	10-2			
Kidney or urinary probl	ems (
disease Dia	lysis			
Other kidney problems	-explain			
Contraction Providence	•			
	_			
Nervous system probl	ems?	Deprocesion		Stroke or transitory ischemic attack
Anxiety		Depression Mental Health		
The intigeneous lies				

E Fainting spells

Mental Health

Vertigo

Other nervous system problems-explain

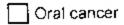
Head and neck problems?

Nose or sinus problems

Impairment of hearing, sight or speech?

Swollen glands

Frequent or severe headaches /migraines



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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 (GERI	D) Ulcers
Other stomach, intestinal or liver problems-explain	
•••···································	
Allergic reactions or other problems?	
Seasonal	
allergies Penicillin Erthromycin C	Codeine Docal anesthetics Decods/flavoring
Other substances- explain	

Blood or auto immune system problems?

Cancer of any type	Chermotherapy
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Radiation treatment	
🛄 Lupus	
Anemia	
AIDS/HIV	

Other problems with the blood or auto immune system-explain

Organ or bone marrow transplant

Mutiple sclerosis

🗌 Hemophilia

Frequent nosebleeds, increased bruising or bleeding

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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. Lacknowledge 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:

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