CONFIDENTIAL MEDICAL-DENTAL HISTORY FORM

NAME (Last, First, Middle):______________________________

DOB:______________

ADDRESS: ______________________________

PREFERRED NAME: ______________ **Social Security Number:**______________

HOME PHONE: ______________ **MARITAL STATUS:** Single / Married / Divorced / Widowed

CELL PHONE: ______________ **SEX:** M / F

EMAIL:______________________________

NAME OF PRIMARY PHYSICIAN:

NAME OF ANY OTHER PHYSICIAN WHO'S CARE YOU ARE CURRENTLY UNDER:

____

Have you ever been a patient in a hospital or had any serious illness? Explain:

____

Check any of the following that you have had or suspected:

YES / NO		YES / NO		YES / NO	
___ ___	Arthritis	___ ___	Hepatitis or Jaundice	___ ___	Fainting Tendency
___ ___	Rheumatic Fever	___ ___	Liver Disease	___ ___	Epilepsy
___ ___	Heart Trouble	___ ___	Cancer or Tumor	___ ___	Thyroid Disease
___ ___	Heart Murmur	___ ___	Tuberculosis	___ ___	Glaucoma
___ ___	High/Low Blood Pressure	___ ___	Diabetes	___ ___	Radiation Treatment
___ ___	Chest Pain	___ ___	Kidney/Bladder Trouble	___ ___	Mental Disorders
___ ___	Stroke	___ ___	Anemia	___ ___	HIV or AIDS
___ ___	Shortness of Breath	___ ___	Lung Disease	___ ___	Joint Replacement / Please List Type/Year:______
___ ___	Asthma or Hay Fever	___ ___	Venereal Disease	___ ___	Blood Transfusion
___ ___	Sinus Trouble	___ ___	Prolonged Bleeding	___ ___	Pregnant
___ ___	Blood Disease	___ ___	Seizures		

Check any of the following that you are taking or have taken:

YES / NO		YES / NO		YES / NO		YES / NO	
___ ___	Cortisone Drugs	___ ___	Anticoagulants	___ ___	Tranquilizers	___ ___	Bisphophonates (Fosamax, Boniva, Zomita, ECT..)
___ ___	Steroids	___ ___	Blood Thinners	___ ___	Sedatives		

Are you allergic to or do you suffer ill effects from any of the following?

YES NO		YES NO		YES NO	
___ ___	Penicillin	___ ___	Codeine	___ ___	Dental Anesthesia
___ ___	Aspirin	___ ___	Household Bleach	___ ___	Other

Please list any current medication or medical condition here or on back of sheet:

____

____

____

The above information is true to the best of my knowledge.

PATIENT or RESPONSIBLE PARTY FOR PATIENT:

Print Name / Relationship to Patient: ______________________________

Signature: ______________________________ **Date:**______________

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PATIENT NUMBER

welcome

Patient's Name ______ Last ______ First ______ Initial ______ Date of Birth

1. Purpose of initial visit ______
2. Are you aware of a problem? ______
3. How long since your last dental visit? ______
4. What was done at that time? ______
5. Previous dentist's name ______
   Address: ______ Tel. ______
6. When was the last time your teeth were cleaned? ______

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

7. Have you made regular visits? .... YES NO
   How often: ______
8. Were dental x-rays taken? .... YES NO
9. Have you lost any teeth or have any teeth been removed? .... YES NO
   Why? ______
10. Have they been replaced? .... YES NO
11. How have they been replaced?
    a. Fixed bridge ______ Age ______
    b. Removable bridge ______ Age ______
    c. Denture ______ Age ______
    d. Implant ______ Age ______
12. Are you unhappy with the replacement? .... YES NO
    If yes, explain ______
13. Would you like to know about permanent replacements? .... YES NO
14. Have you ever had any problems or complications with previous dental treatment? .... YES NO
    If yes, explain: ______
15. Do you clench or grind your teeth? .... YES NO
16. Does your jaw click or pop? .... YES NO
17. Have you experienced any pain or soreness in the muscles or your face or around your ear? .... YES NO
18. Do you have frequent headaches, neckaches or shoulder aches? .... YES NO
19. Does food get caught in your teeth? .... YES NO
20. Are any of your teeth sensitive to: ☐ Hot? ☐ Cold? ☐ Sweets? ☐ Pressure?
21. Do your gums bleed or hurt? .... YES NO
    When? ______
22. Do you experience dry mouth? .... YES NO
23. How often do you brush your teeth? ______ When? ______
24. Do you use dental floss? .... YES NO
    How often? ______
25. Are any of your teeth loose, tipped, shifted or chipped? .... YES NO
26. Are you unhappy with the appearance of your teeth? .... YES NO
27. How do you feel about your teeth in general? ______
28. Do you feel your breath is offensive at times? .... YES NO
29. Have you ever had gum treatment or surgery? .... YES NO
    What? ______
    Where? ______
    When? ______
30. Have you had any orthodontic work? ______
31. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? ______
32. Do you have any questions or concerns? .... YES NO

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S / GUARDIAN'S SIGNATURE ______ DATE ______

DENTIST'S SIGNATURE ______ DATE ______

ANEST.

MED. ALERT

DENTAL HISTORY

Form No. T150DH

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____
[Insert Name of Practice]

SECTION A: The Patient.

Name: ______________________________

Address: ______________________________

Telephone: ______________________________ E-mail: ______________________________

Patient Number: ______________________________ Social Security Number: ______________________________

SECTION B: Acknowledgement of Receipt of Privacy Practices Notice.

I, ______________________________, acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Signature: ______________________________ Date: ______________________________

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name: ______________________________

Relationship to Individual: ______________________________

SECTION C: Good Faith Effort to Obtain Acknowledgement of Receipt.

Describe your good faith effort to obtain the individual's signature on this form: ______________________________

____

____

Describe the reason why the individual would not sign this form: ______________________________

____

____

SIGNATURE.

I attest that the above information is correct.

Signature: ______________________________ Date: ______________________________

Print name: ______________________________ Title: ______________________________

Include this acknowledgement of receipt in the individual's records.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE

Form No. T303HA

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