Dentistry West
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Medical & Dental History Form

Patient Name: _____ (Last) _____ (First) ___ (M)

_____ (Preferred Name)

Date of Birth: _____

Home address:

_____

_____

Do you have dental insurance? Is so, please provide the company name, telephone number and your subscriber number:

_____

_____

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that cares for your overall health and well-being.

Would you consider yourself to be in fairly good health? ◯ Yes ◯ No

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

What is the date (or approximate date) of your last medical exam?

_____

_____

Your Primary Care Physician's name, address, & phone number:

_____

_____

Please mark any of the following to indicate Yes in response to the question:

☐ Have you ever had complications following dental treatment?

☐ Are you currently under the care of a physician due to a specific condition?

☐ Have you been hospitalized within the last 5 years due to a surgery or illness?

☐ Do you use tobacco/nicotine (smoke, chew or vaping)?

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

_____

_____

Are you pregnant? ◯ Yes ◯ No

If Yes, when is the due date? _____

Please indicate if you have experienced any of the following:

☐ Acid Reflux	☐ A-Fib	☐ Allergies/Allergic	☐ Anemia
☐ Aneurysm	☐ Arthritis	☐ Asthma	☐ Autoimmune Disease
☐ Back Pain	☐ Blood Thinner	☐ Bone Replacement Med	☐ Cancer
☐ Codeine Allergy	☐ Dementia	☐ Diabetes	☐ Digestive Issues
☐ Dizziness/Vertigo	☐ Emphysema/COPD	☐ Epilepsy	☐ Excessive Bleeding
☐ Glaucoma	☐ Head Trauma	☐ Heart Attack	☐ Heart Disease
☐ Heart Murmur	☐ Hepatitis	☐ High Cholesterol	☐ High/Low BP
☐ HIV/AIDS	☐ Kidney Disease	☐ Latex Allergy	☐ Liver Disease
☐ Mental Disorders	☐ Migraines	☐ Osteoporosis	☐ Pacemaker
☐ Pen/Sulfa Allergy	☐ Radiation Treatment	☐ Respiratory Problems	☐ Rheumatic Fever
☐ Seizures	☐ Sinus Problems	☐ Sleep Apnea/CPAP	☐ Stroke
☐ Surgery	☐ Thyroid	☐ TMD/TMJ	☐ Tonsillectomy
☐ Tremors	☐ Tuberculosis	☐ Ulcers	☐ Venereal Disease

List any other health related issues:

_____

_____

List any allergies, including allergies to medications:

_____

_____

List any medications or supplements that you are currently taking:

_____

_____

_____

Do you need to be pre-medicated with antibiotics before dental appointments? ◯ Yes ◯ No

What is the reason for your dental visit today?

_____

_____

Prior dentist name and date of last visit (or approximate date):

_____

_____

What was done on your last dental visit?

_____

_____

How frequently do you brush your teeth?

◯ 3 (+) a day ◯ Twice a day ◯ Once a day ◯ Weekly ◯ Seldom

How frequently do you floss your teeth?

◯ 1 (+) a day ◯ 2 - 6 weekly ◯ 1 - 6 monthly ◯ Seldom ◯ Never

Please mark any of the following to indicate Yes in response to the question:

☐ Do your gums bleed when you brush or floss?

☐ Do your teeth experience sensitivity to cold or hot temperatures?

☐ Are any of your teeth currently causing you pain?

☐ Do you grind your teeth (either consciously or during sleep)?

☐ Are any of your teeth loose, or are you concerned about any teeth loosening?

☐ Do you currently have any dental implants, dentures, or partials?

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

_____

_____

If you could change anything about your mouth, teeth, or smile, what would it be?

_____

_____

☐ **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 detal 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 I may be billed for this remaining balance. 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: _____

Dentist's Signature:

Signature _____ _____

Date _____

Response Date: _____