Healthy Smiles Dentistry

Medical History Form

Today's Date: ___________

Patient name ______________________________ ___________________________ ______ Birth date _________

Last *First* *M.I*

Date of last dental visit ___________ Date of last x-rays _________ Type of cleaning done: ☐ deep ☐ regular

Is there any pending treatment that was proposed by your last dentist? ☐ Yes ☐ No______________________

Reason for leaving previous dentist?____

Are you aware of any muscle or jaw clicking and pain or clenching/grinding? ☐ Yes ☐ No

Are you aware of snoring or sleep apnea? ☐ Yes ☐ No, if yes, Do you wear a CPAP ☐ Yes ☐ No

Do you wear any dental appliance such as night guard, dentures, retainers, snoring appliance? ☐ Yes ☐ No

Any dental concerns you would like to be addressed today? ____

Are you happy about your smile? ☐ Yes ☐ No, What would you like to change? __________________________

Are you under the care of a physician? ☐ Yes ☐ No If yes, what condition(s) are you being treated for?

____

Doctor's name ____________________________ Phone (_____)______________ Fax (_____)______________

Date of last physical _______________ Height _________________ Weight ______________________

Previous hospitalization(s) and reason(s) ____

____

For women. Are you, or do you suspect that you are pregnant? ☐ Yes ☐ No Due date ________

Are you nursing? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No

Have you ever had any of the following? *Check all that apply*

☐ Seasonal Allergies
☐ Arthritis or Rheumatism
☐ Artificial Joints
☐ Chest Pains
☐ Pacemaker
☐ Artificial Heart Valves, Screws, etc
☐ Congenital Heart disease
☐ Infective Endocarditis
☐ Cardiac Transplant
☐ Heart Murmur
☐ Heart Problems________________
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Mitral Valve Prolapse
☐ Rheumatic Fever
☐ Circulatory Problems
☐ Bleeding Abnormally
☐ Hemophilia
☐ Blood Disease
☐ Blood Transfusion

☐ Cancer
☐ Chemotherapy
☐ Radiation Treatment
☐ Chemical Dependency or Recreational Drug Abuse
☐ Chronic Diarrhea
☐ Cortisone-Steroid Treatment
☐ Diabetes
☐ Glaucoma
☐ Thyroid Trouble high or low
☐ Kidney or bladder Disease
☐ Dialysis
☐ Headaches
☐ Nervous Problems
☐ Epilepsy, Convulsions or Seizures
☐ Psychiatric Care
☐ Stroke ________________

☐ Recent Weight Loss
☐ Respiratory Disease
☐ Asthma
☐ Shortness of Breath
☐ Sinus Problems/Hayfever
☐ Special Diet
☐ Swollen Neck Glands
☐ Swollen Ankles
☐ Ulcer
☐ Fainting
☐ Sleep Apnea
☐ Tobacco Use (smoking or dip)
☐ Infectious Disease _________
☐ Hepatitis, Jaundice or Liver Disease
☐ History of HPV (Human Papillomavirus)
☐ HIV/AIDS
☐ Tuberculosis
☐ Sexually Transmitted Disease
☐ Family History of Diabetes, Heart Disease, or Stroke

Allergies. Do you have any drug allergies or have you ever had an adverse reaction to any medication, anesthetic, materials, or latex? ☐ Yes ☐ No If yes, what do you react to ____________________________

Has your doctor ever told you that you need to take antibiotic premedication prior to any dental appointment or procedure? (This is usually due to having had joint replacement, heart surgery, chemotherapy, etc.)
☐ Yes ☐ No If yes, explain. ____

Please list all prescription and over-the-counter medications you are currently taking and the reasons you take them. *(Attach list if needed)* ____

____

Do you have any disease or condition not listed on the previous page, or anything about your health problem that we have not covered? ☐ Yes ☐ No If yes, please explain. ____

Emergency Contact Information. Please list the names and telephone numbers of two relatives (or friends) not living with you that we may contact in the case of an emergency.

Name ______________________________ Relationship __________ Phone (____)__________

Address ____

Name ______________________________ Relationship __________ Phone (____)__________

Address ____

Release. I AUTHORIZE THE DENTIST TO PERFORM DIAGNOSTIC PROCEDURES AND TREATMENT AS MAY BE NECESSARY FOR PROPER DENTAL CARE. I AM RESPONSIBLE TO INFORM THIS OFFICE OF ANY CHANGE IN HEALTH HISTORY.

X ____ ____________

Signature *Date*

Health Information Authorization. I AUTHORIZE THE DENTAL OFFICE TO SHARE MY PROTECTED HEALTH INFORMATION WITH THE FOLLOWING PERSONS:

Name ______________________________ Relationship __________ Phone (____)__________

Name ______________________________ Relationship __________ Phone (____)__________

Name ______________________________ Relationship __________ Phone (____)__________

HIPAA Release (Privacy Practices Documentation). I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES AND I HAVE BEEN PROVIDED AN OPPORTUNITY TO REVIEW IT.

________________________________ ____________________ __________

Patient Name (please print) *Signature* *Date*

To Be Completed by Front Office

Written acknowledgement could not be documented due to the following reason(s):

☐ patient refusal to sign

☐ personal representative not available to sign

☐ language, communication, or effects of disability impeded acknowledgement

☐ emergency care impeded acknowledgement

☐ other, please specify