Comprehensive Patient Information and Medical History

Patient: Submitted: 8/9/2024

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws.

PATIENT INFORMATION

Patient Name:
Date of Birth:
Gender:
Social Security Number:
Primary Phone Number: Email Address:

EMERGENCY CONTACT INFORMATION

REFERRAL SOURCE

How did you hear about our office?
If applicable, provide the name of who we can thank:

Pharmacy Information

Do you have a preferred pharmacy that you would like us to keep on file? Yes [ ] No [ ]
Pharmacy Name

DENTAL INFORMATION

DENTAL HEALTH

PLEASE SELECT YES OR NO TO THE FOLLOWING DENTAL HEALTH QUESTIONS:

Question	Yes	No	Question	Yes	No
Do you have any immediate dental concerns?	Yes [ ]	No [ ]	Are you currently experiencing dental pain or discomfort?	Yes [ ]	No [ ]
Have you had any problems with previous dental treatment?	Yes [ ]	No [ ]	Have you ever had a serious injury to your head or mouth?	Yes [ ]	No [ ]
Have you ever had teeth become loose, without injury?	Yes [ ]	No [ ]	Have you had any periodontal (gum) treatments?	Yes [ ]	No [ ]
Do your gums bleed when you brush or floss?.	Yes [ ]	No [ ]	Have you had any cavities in the last 3 years?	Yes [ ]	No [ ]
Are your teeth sensitive to cold, hot, sweets or pressure?.	Yes [ ]	No [ ]	Do you ever have times your mouth feels dry?	Yes [ ]	No [ ]
Do you brux, grind, or clench your teeth?	Yes [ ]	No [ ]	Do you have earaches or neck pains?	Yes [ ]	No [ ]
Do you have any clicking, popping or discomfort in the jaw?	Yes [ ]	No [ ]	Have your teeth become shorter, thinner, or worn in the last 5 years?	Yes [ ]	No [ ]

Comprehensive Patient Information and Medical History

Patient: Submitted: 8/9/2024

Have you ever had a sleep test?	Yes [ ]	No [ ]	Have you ever had orthodontic (braces) treatment?	Yes [ ]	No [ ]
Do you have sores or ulcers in your mouth?	Yes [ ]	No [ ]	Do you wear dentures or partials?	Yes [ ]	No [ ]
Is there anything you would like to change about your smile?	Yes [ ]	No [ ]			

DENTAL HISTORY

Complete the following fields if you are NEW PATIENT or if you have regular appointments with another dental provider.

Date of your last dental exam
Date of your last dental x-rays?

PREVIOUS OR OTHER DENTAL PROVIDER INFORMATION

Dental Provider or Practice Name:	Dental Provider or Practice Phone#:

MEDICAL INFORMATION

Do you use tobacco (smoking, snuff, chew, vaping)?	Yes [ ]	No [ ]	Do you consume alcohol or use recreational drugs?	Yes [ ]	No [ ]
Have you had a serious illness, operation or been hospitalized in the past 5 years?	Yes [ ]	No [ ]	Have you been instructed by a physician or dentist to take antibiotics prior to dental treatment for a heart condition or joint replacement?	Yes [ ]	No [ ]
Are you currently under the care of a physician?	Yes [ ]	No [ ]			

***If you are currently under the care of a physician, please complete the "Physician Information" section.*

**PHYSICIAN INFORMATION

Physician Name: Physician Phone Number:
Date of last visit:
Did you have bloodwork completed as part of your last visit? Yes [ ] No [ ]

HABITS

PLEASE SELECT YES OR NO TO THE FOLLOWING:

Speech problems	Yes [ ]	No [ ]	Mouth breather	Yes [ ]	No [ ]
Thumb/finger sucking	Yes [ ]	No [ ]	Tongue Thrust	Yes [ ]	No [ ]
Lip sucking/biting	Yes [ ]	No [ ]	Nail biting	Yes [ ]	No [ ]

MEDICATION

Are	Yes [ ]	No [ ]	Have	Yes [ ]	No [ ]	Are	Yes [ ]	No [ ]	Are	Yes [ ]	No [ ]

Comprehensive Patient Information and Medical History

Patient: Submitted: 8/9/2024

you pr escribe d blood thinner s? (Asp irin, He parin, Warfar in, etc.)	you taken medica tions contai ning bi sphosp honate s?	you cu rrently taking any GLP-1 medica tions for weight loss?	you taking any pre scripti on or over the co unter medica tion(s)?

Please list all prescribed or over the counter medication(s).

Medication	Dosage	Frequency

ALLERGIES

PLEASE SELECT YES OR NO TO THE FOLLOWING:

Anesthesia	Yes [ ]	No [ ]	Aspirin	Yes [ ]	No [ ]
Barbiturates, sedatives, or sleeping pills	Yes [ ]	No [ ]	Codeine or other narcotics	Yes [ ]	No [ ]
Sulfa drugs	Yes [ ]	No [ ]	Tetracycline/Erythromycin / Penicillin / Other antibiotics	Yes [ ]	No [ ]
Jewelry / Metals	Yes [ ]	No [ ]	Latex (rubber)	Yes [ ]	No [ ]
Hay fever/ Seasonal	Yes [ ]	No [ ]			

Do you have any allergies not listed above? Yes [ ] No [ ]

Please list any allergies not listed above:

Allergies

Comprehensive Patient Information and Medical History

Patient: Submitted: 8/9/2024

Allergies

JOINT REPLACEMENT/IMPLANT

Have you ever undergone a total orthopedic joint replacement or had any orthopedic implants placed in your body? Yes [ ] No [ ]

Date Of Replacement or Implant:

HEART CONDITIONS

PLEASE SELECT YES OR NO TO THE FOLLOWING:

Condition	Yes	No	Condition	Yes	No
Arteriosclerosis / Coronary artery disease	Yes [ ]	No [ ]	Artificial (prosthetic) heart valve	Yes [ ]	No [ ]
Cardiac stent	Yes [ ]	No [ ]	Cardiovascular disease	Yes [ ]	No [ ]
Chest pain / Angina	Yes [ ]	No [ ]	Congestive Heart Failure	Yes [ ]	No [ ]
Congenital heart disease (CHD)	Yes [ ]	No [ ]	Heart Attack	Yes [ ]	No [ ]
Heart murmur	Yes [ ]	No [ ]	High blood pressure	Yes [ ]	No [ ]
History of Endocarditis	Yes [ ]	No [ ]	Low blood pressure	Yes [ ]	No [ ]
Mitral valve prolapse	Yes [ ]	No [ ]	Pacemaker	Yes [ ]	No [ ]

MEDICAL CONDITIONS, DISEASES, AND PROBLEMS

PLEASE SELECT YES OR NO TO THE FOLLOWING:

Condition	Yes	No	Condition	Yes	No
Pregnant/Nursing?	Yes [ ]	No [ ]	Taking birth control pills or hormonal replacement?	Yes [ ]	No [ ]
Anemia	Yes [ ]	No [ ]	Autoimmune disease (e.g., rheumatoid arthritis, lupus, scleroderma)	Yes [ ]	No [ ]
Hemophilia / Abnormal bleeding	Yes [ ]	No [ ]	Blood transfusion	Yes [ ]	No [ ]
Arthritis / Pain in joints	Yes [ ]	No [ ]	HIV + / AIDS	Yes [ ]	No [ ]
Asthma / Breathing problems	Yes [ ]	No [ ]	Tuberculosis	Yes [ ]	No [ ]
Emphysema / Bronchitis / Persistent cough	Yes [ ]	No [ ]	Sinus trouble	Yes [ ]	No [ ]
Rheumatic fever	Yes [ ]	No [ ]	Hearing or Vision Impairment	Yes [ ]	No [ ]
Cancer / Chemotherapy / Radiation	Yes [ ]	No [ ]	Chronic pain	Yes [ ]	No [ ]
Diabetes	Yes [ ]	No [ ]	Glaucoma	Yes [ ]	No [ ]
Hepatitis / Jaundice / Liver disease	Yes [ ]	No [ ]	Mental health disorders(ie Anxiety, Depression, Bipolar)	Yes [ ]	No [ ]
Neurological disorders	Yes [ ]	No [ ]	Snoring	Yes [ ]	No [ ]
Sleep disorder	Yes [ ]	No [ ]	Severe / Rapid weight loss	Yes [ ]	No [ ]
Eating disorder / Malnutrition	Yes [ ]	No [ ]	Gastrointestinal disease	Yes [ ]	No [ ]
Reflux / Persistent heartburn	Yes [ ]	No [ ]	Sores / Ulcers in the mouth	Yes [ ]	No [ ]

Comprehensive Patient Information and Medical History

Patient: Submitted: 8/9/2024

Thyroid problems	Yes [ ]	No [ ]	Stroke	Yes [ ]	No [ ]
Epilepsy / Seizures	Yes [ ]	No [ ]	Dizziness / Fainting	Yes [ ]	No [ ]
Recurrent Infections	Yes [ ]	No [ ]	Kidney problems	Yes [ ]	No [ ]
Night sweats	Yes [ ]	No [ ]	Osteoporosis	Yes [ ]	No [ ]
Persistent swollen glands in neck	Yes [ ]	No [ ]	Frequent / Severe headaches	Yes [ ]	No [ ]
Sexually transmitted disease	Yes [ ]	No [ ]	Difficulty urinating / Prostate	Yes [ ]	No [ ]
Do you have any other diseases, conditions, problem, or special needs or accommodations not listed above?				Yes [ ]	No [ ]

Please list any other diseases, conditions, problem, special needs or accommodations not listed above.

Problems

SIGNATURE

I consent to use Electronic Records and Signatures

I consent to use Electronic Records and Signatures: [ ]

I certify that to the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients') health. I acknowledge that It is my responsibility to inform the dental team of any changes in medical status and I will not hold my doctor, affiliated entities, or any other member of his/her staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature:
Relationship To Patient: