MEDICAL RECORD

First Name : ______ Last Name: ______ Date: / /

Do you have a personal physician? Yes / No | Physician's Name: ______ | Physician's Ph #: ______ | Date of Last Visit: / /

Travelled outside the U.S. in the last 6 months? Yes / No | Please specify where: ______ | For how long? ______

Anything you would like to discuss with the doctor in private? Yes / No

DENTAL HISTORY

Why have you come to the dentist today? ______

If you are a new patient, when was the last time you saw a dentist? ______ Why ? ______

Your current dental health is: *Good / Fair / Poor*

Have you ever taken *Phen – Phen / Redux & Pondimin*? *Yes / No*

Have you ever taken *Bisphosphonates*? *Yes / No*

Do you require antibiotics before dental treatment? *Yes / No*

Are your teeth sensitive to heat, cold, currently in pain? *Yes / No*

Have you ever had gum treatment or bleeding gums? *Yes / No*

Have you ever had a problem w/ any previous dental work? *Yes / No*

Have you ever experienced pain/discomfort in your jaw joint-TMJ? *Yes / No*

Do you like your smile? *Yes / No*

Do you like the shade of your teeth? *Yes / No*

Would you like your teeth to be whitened? *Yes / No*

ALLERGENS

☐ No known allergens ☐ Aspirin ☐ Codeine ☐ Iodine ☐ Local anesthetics ☐ Penicillin ☐ Sedatives ☐ Sulfa drugs

☐ Antibiotics ☐ Barbiturates ☐ Erythromycin ☐ Latex ☐ Metals ☐ Plastic ☐ Sleeping pills ☐ Tetracycline

CURRENT MEDICATIONS

MEDICINE	DOSAGE / FREQUENCY	REASONS

Patient Signature: ______ **Date:** ______

MEDICAL HISTORY

MEDICAL CONDITION	NEVER	CURRENT	PAST	DATE/ NOTE	MEDICAL CONDITION	NEVER	CURRENT	PAST	DATE/ NOTE
Acid Reflux					Hospitalized				
Anemia					Hypertension				
Atherosclerosis					Hypoglycemia				
Arthritis					Immune System Disorder				
Asthma					Insomnia				
Autoimmune Disorder					Ischemic Heart Disease (reduced blood supply)				
Bleeding Easily					Kidney Problems				
Blood Pressure - High					Liver Disease				
Blood Pressure - Low					Meniere's Disease				
Bruising Easily					Metal Rods, Pins Or Implants				
Cancer					Mitral Valve Prolapse				
Chemotherapy					Mood Disorder				
Chronic Fatigue					Multiple Sclerosis				
Chronic Pain					Muscular Dystrophy				
COPD					Nasal Allergies				
Coronary Heart Disease					Neuralgia				
Current Pregnancy					Osteoarthritis				
Depression					Osteoporosis				
Diabetes					Parkinson's Disease				
Difficulty Sleeping					Prior Orthodontic Treatment				
Dizziness					Psychiatric Problems				
Emphysema					Radiation Treatment				
Epilepsy					Rheumatic Fever				
Excessive Daytime Sleepiness					Rheumatoid Arthritis				
Fibromyalgia					Shingles				
Frequent Headaches					Sickle Cell Disease/Traits				
Glaucoma					Sinus Problems				
Gout					Sleep Apnea				
Heart Attack					Stroke				
Heart Murmur					Tendency For Ear Infections				
Heart Pacemaker					Thyroid Disorder				
Heart Valve Replacement					Tuberculosis				
Hemophilia					Tumors				
Hepatitis					Ulcers				
Herpes / Fever Blisters					Urinary Disorders				

Other (Please Specify): ______________________________

Patient Signature: ______________________________ **Date:** / /

CONFIDENTAL MEDICAL HISTORY

MEDICAL CONDITION	NEVER	CURRENT	PAST	DATE/ NOTE	MEDICAL CONDITION	NEVER	CURRENT	PAST	DATE/ NOTE
Recreational Drugs					Other (Please Specify):				
HIV / AIDS					Other (Please Specify):				

SURGICAL OPERATIONS

☐ Appendectomy ☐ Ear ☐ Heart ☐ Lung ☐ Thyroid ☐ Uvulectomy ☐ Other: ______

☐ Back ☐ Gallbladder ☐ Hernia repair ☐ Nasal ☐ Tonsillectomy ☐ Periodontal ☐ Other: ______

FAMILY HISTORY

Has any member of your family (parent, sibling, or grandparent) had:

☐ Cancer ☐ Diabetes ☐ Stroke ☐ Obesity ☐ Father snores ☐ Father has sleep apnea

☐ Heart disease ☐ High blood pressure ☐ Sleep disorder ☐ Thyroid disorder ☐ Mother snores ☐ Mother has sleep apnea

SOCIAL HISTORY

Patient's Occupation: ______ Employer: ______

Tobacco Use: Cigarettes ☐ Never smoked ☐ Current smoker ☐ *# of packs per day* ☐ *# of years* ☐ Quit When? ______

Other tobacco: ☐ Pipe ☐ Cigar ☐ Snuff ☐ Chew

Alcohol Use: Do you drink alcohol? ☐ Yes ☐ No If yes, # of drinks per week: ☐

Caffeine Intake: ☐ None ☐ Coffee / Tea/ Soda # Cups / day ☐

Additional: ☐ Regular exercise

DECLARATION

Because of HIPAA Federal regulations protecting your privacy, we wish to inform you that we will release no information about you without your consent. By agreeing to this consent, you permit the release of any information to or from your dental practitioner as required including a full report of examination findings, diagnosis and treatment program to any referring or treating dentist or physician. You understand that you are financially responsible for all charges whether or not paid by insurance. Your dental practitioner may use your health care information and may disclose such information to your Insurance Company(ies) and their agents for the purpose of obtaining payment for service and determining insurance benefits or the benefits payable for related services.

I certify that the medical history information is complete and accurate.

I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Patient Signature: ______ **Date:** / /

Doctor Signature: ______ **Date:** / /