Medical and Dental
History Questionnaire

Welcome! So that we may provide you with the best possible care, please complete both sides of this Medical/dental history form. All information is completely confidential.

Date_____

Name_____Address_____Home Phone ( ) _____

City/Town_____State_____Zip Code_____Cell Phone (____)_____

Date of Birth_____Occupation_____EMAIL: _____

Employer's Name_____Employer's Address_____Social Security#_____

Patient's Status: Child ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐

Spouse's Name_____Spouse's Address_____

Dental Insurance Coverage Yes ☐ No ☐ Name of Insurance Co._____

Agreement/I.D. Number_____Group Number_____Insured Social Security #_____

Person Responsible for Account_____Relationship_____Insured Date of Birth_____

Whom may we thank for referring you?_____

Name and phone number of Physician _____

Name and phone number of person to contact in case of emergency (someone who does not live at your address)

_____

Have you been a patient in a hospital in the past 2 years?	Yes ☐	No ☐
Have you been under the care of a Doctor during the past 2 years?	Yes ☐	No ☐
Are you allergic to any medication or substance? (Penicillin, codeine, _____)	Yes ☐	No ☐
Have you ever had an excessive bleeding requiring special treatment?	Yes ☐	No ☐
(Women) Are you pregnant?	Yes ☐	No ☐
Are you taking birth control pills?	Yes ☐	No ☐
Is there any history of diabetes or heart disease in your family?	Yes ☐	No ☐

Indicate any of the following, which you have had, or have at present. Check all that apply.

☐ Heart (Surgery, Disease, Attack)	☐ Ulcers	☐ Diabetes Type 1__ Type 2__
☐ Chest pain	☐ Thyroid Problems	☐ A.I.D.S
☐ Congenital Heart Disease	☐ Hepatitis A (infectious) B (serum) C	☐ Venereal Disease
☐ Heart Murmur	☐ Glaucoma	☐ H.I.V. Positive
☐ High Blood Pressure	☐ Contact Lenses	☐ Cold Sores/Fever Blisters
☐ Mitral Valve Prolapse	☐ Emphysema	☐ Blood Transfusion
☐ Artificial Heart Valve	☐ Chronic Cough	☐ Hemophilia
☐ Heart Pacemaker	☐ Tuberculosis	☐ Sickle Cell Disease
☐ Rheumatic Fever	☐ Asthma	☐ Bruise Easily
☐ Arthritis/Rheumatism	☐ Diagnosed Metal Allergy	☐ Liver Disease
☐ Cortisone Medicine	☐ Latex Sensitivity	☐ Yellow Jaundice
☐ Swollen Ankles	☐ Allergies or Hives	☐ Neurological Disorders
☐ Stroke	☐ Sinus Trouble	☐ Epilepsy or Seizures
☐ Diet (Special/Restricted)	☐ Radiation Therapy	☐ Fainting or Dizzy Spells
☐ Artificial Joints (hips, knees, etc)	☐ Chemotherapy	☐ Nervous/Anxious
☐ Kidney Trouble	☐ Tumors/Growths	☐ Psychiatric Treatment

Other

Have you taken any kind of medicine or drugs in the past year?_____
Summary of Medical History including any medications take.
B.P._____ Pulse_____ Resp._____

What is the reason for your visit today?_____
Date of last Dental visit_____Last Dental Cleaning_____

Are any of your teeth sensitive to:

Hot or Cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No

Have you ever noticed:

Mouth odors or bad tastes?	Yes	No
Cold sores, blisters, or oral lesions?	Yes	No
Loose teeth or change in bite?	Yes	No
Food caught in between your teeth?	Yes	No

Do you:

Clench or grind your teeth?	Yes	No
Have bleeding gingival tissues (gums)?	Yes	No
Or have you experienced pain/discomfort in your jaw (TMJ)?	Yes	No
Have pain or clicking in joint just in front of ear?	Yes	No
Smoke/chew tobacco?	Yes	No

Are you satisfied with your teeth's appearance?	Yes	No
Would you like to keep your teeth all your life?	Yes	No
Would you like to be shown how to maintain your teeth?	Yes	No
Would you like to prevent partials/dentures?	Yes	No
Do you experience stress of anxiety when you visit a dental office?	Yes	No

I hereby give consent for treatment and the use of such local anesthetic or the taking of any Radiographs, which may be deemed advisable by the Doctor. I hereby understand that payment is due at time of services are rendered and that I am responsible for all balances including late fees, broken appointments fees, collection fees, and/or unpaid balances or copayments by the insurance company.
I hereby acknowledge that all information I have provided is to best of my ability and can/ will be used for the treatment, payment, and health care operations.
Signature of Patient, Parent, or Legal Guardian_____Date_____
Thank you for your cooperation in filling out this questionnaire. It will enable us to attend to your dental needs in the most efficient, comfortable, and safe manner possible.