Medical History

Although dental providers primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have/had, medications that you may be taking, and your family history have an important impact on the dentistry you will receive. Thank you for answering the following questions.

Name: _____ **Date of last medical exam:** _____

What was the exam for? _____ **Current Physician:** _____

	Y	N
Have you ever been hospitalized or had a major operation?	☐	☐
Are you under the care of a physician?	☐	☐
Have you ever had serious head or neck injury?	☐	☐
Do you take or have you taken Phen-Fen or Redux?	☐	☐
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐	☐
Are you on a special diet?	☐	☐
Do you use Tobacco?	☐	☐
Do you use controlled substances?	☐	☐
Women		
Are you pregnant or trying to get pregnant?	☐	☐
Due Date:_____		
Are you taking contraceptives?	☐	☐
Are you nursing?	☐	☐

Are you allergic to any of the following?

- ☐ Antibiotic: _____
- ☐ Penicillin
- ☐ Sulfa Drug
- ☐ Aspirin
- ☐ Local Anesthetics
- ☐ Acrylic
- ☐ Codeine
- ☐ Metal: _____
- ☐ Latex
- ☐ Other: _____

CHECK ALL THAT APPLY:

	HAVE	HAD	FAMILY HISTORY
Acid Reflux	☐	☐	☐
Aids/ HIV Positive	☐	☐	☐
Alzheimer's disease	☐	☐	☐
Anemia	☐	☐	☐
Angina	☐	☐	☐
Arthritis/Gout	☐	☐	☐
Artificial Heart Valve	☐	☐	☐
Artificial Joint	☐	☐	☐
What Joint? _____			
When? _____			
Asthma	☐	☐	☐
Blood Disease	☐	☐	☐
Blood Transfusion	☐	☐	☐
Breathing Problems	☐	☐	☐
Bruise Easily	☐	☐	☐
Cancer	☐	☐	☐
Type? _____			
Chemotherapy	☐	☐	☐
When? _____			
Chest Pains	☐	☐	☐
Cold Sores/Fever Blisters	☐	☐	☐
Congenital Heart Disease	☐	☐	☐
Diabetes	☐	☐	☐
Drug Addiction	☐	☐	☐
Dry Mouth	☐	☐	☐
Eating Disorder	☐	☐	☐
Emphysema	☐	☐	☐

	HAVE	HAD	FAMILY HISTORY
Epilepsy/Seizure	☐	☐	☐
Excessive Thirst	☐	☐	☐
Fainting/ Dizziness	☐	☐	☐
Frequent Cough	☐	☐	☐
Frequent Diarrhea	☐	☐	☐
Frequent Headaches	☐	☐	☐
Glaucoma	☐	☐	☐
Hay Fever	☐	☐	☐
Heart Attack/Failure	☐	☐	☐
Date: _____			
Heart Murmur	☐	☐	☐
Heart Pace Maker	☐	☐	☐
Heart Trouble/Disease	☐	☐	☐
Hemophilia	☐	☐	☐
Hepatitis A	☐	☐	☐
Hepatitis B or C	☐	☐	☐
Herpes	☐	☐	☐
High Blood Pressure	☐	☐	☐
High Cholesterol	☐	☐	☐
Hives or Rash	☐	☐	☐
Hypoglycemia	☐	☐	☐
Inflammatory Disease	☐	☐	☐
Type? _____			
Irregular Heartbeat	☐	☐	☐
Kidney Problems	☐	☐	☐
Leukemia	☐	☐	☐
Liver Disease	☐	☐	☐

	HAVE	HAD	FAMILY HISTORY
Low Blood Pressure	☐	☐	☐
Lung Disease	☐	☐	☐
Lupus	☐	☐	☐
Mitral Valve Prolapse	☐	☐	☐
Osteoporosis	☐	☐	☐
Pain in Jaw Joints	☐	☐	☐
Parathyroid Disease	☐	☐	☐
Psychiatric Care	☐	☐	☐
Radiation Treatments	☐	☐	☐
When? _____			
Recent Weight Loss	☐	☐	☐
Renal Dialysis	☐	☐	☐
Rheumatism	☐	☐	☐
Shingles	☐	☐	☐
Sickle Cell Disease	☐	☐	☐
Sinus Trouble	☐	☐	☐
Sleep Apnea	☐	☐	☐
Do/Did you wear a c-pap?	Y ☐	N ☐	
Sexually Transmitted Disease	☐	☐	☐
Stomach/ Intestinal Disease	☐	☐	☐
Stroke	☐	☐	☐
Swelling of Limbs	☐	☐	☐
Thyroid Disease	☐	☐	☐
Tonsillitis	☐	☐	☐
Tuberculosis	☐	☐	☐
Tumors or Growths	☐	☐	☐
Ulcers	☐	☐	☐

HAVE EVER HAD ANY SERIOUS ILLNESS NOT LISTED ABOVE? **YES** ☐ **NO** ☐

If yes, please explain:_____

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 patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian: _____ **Date:** _____

Patient Information

Date _____

Patient Name _____
(Last) (First) (Middle)

Address _____
(Street/Road/Apartment #) (City) (State) (Zip)

Home #_____ Cell # _____ **Okay to Text Cell: Yes or No**

Work #_____ **What number is best to call? (circle one) Home Cell Work**

Email _____ **How would you prefer to be contacted to confirm appointments? Call Text Email**

D.O.B. _____ Social Security # _____ Sex: M F

Employer _____

Spouse/Partner/ Emergency Contact _____

Home #_____ Cell # _____ Work # _____

*****FOR PARENTS OR GUARDIANS ONLY:**

Name of Parent/Guardian _____
(Last) (First) (Middle)

Home # _____ Work #_____ Cell #_____

Additional Parent/Guardian_____ Preferred #_____
(Last) (First) (Middle)

Assignment of Release:

I hereby authorize payment directly to Renée L. I. Owen, DDS for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

**** Signature** _____ **Date** _____

Dental History

Date of last dental exam: _____

Do you have or have you had any of the following. Please check all that apply:

- ☐ Discomfort or Pain Where? _____
- ☐ Sensitivity to hot, cold, sweets (Circle)
- ☐ Difficulty Chewing
- ☐ Aching/Clicking/Popping in your jaw joint (Circle)
- ☐ Loose/Broken-Teeth/Fillings Where? _____
- ☐ Clenching or Grinding (Circle)
- ☐ Bad Breath
- ☐ Sore(s)/Growth(s) in Mouth Where? _____
- ☐ Food Collection Between Teeth Where? _____
- ☐ Anxiety During Dental Treatment
- ☐ Orthodontic Therapy (braces) When/Where? _____
- ☐ Other Concerns? _____
- ☐ Is there anything you would like to change about your teeth? _____

Medications

Please list any medications you are currently taking including herbals:

OVER→