Medical, Dental History Form

Date _____

Name _____ (Last / First / Middle)
Cell Phone (____)_____
Home Phone (____)_____
Address _____ (Number, Street)
Business Phone (____)_____
City _____ State_____ Zip Code _____
Occupation _____ Social Security _____
Date of Birth ____/____/___ (mo./day/yr.) Sex: M __ F __ Height _____ Weight _____ Single _____ Married _____
Name of Spouse _____ Closest Relative _____ Phone (____)_____
Email:_____
Referred by _____

MEDICAL HISTORY

Are you being treated for a current medical condition _____
_____

Physician name_____Phone #_____
Address_____

History of Hospitalizations, Surgeries, Major Illnesses_____
_____
_____

Medications

_____ _____
_____ _____
_____ _____
_____ _____

❑ Artificial joints, Prosthesis: Date _____ Location _____

❑ Are you or have you taken Fosamax (bisphosphonate)

Check all that apply

❑ Heart Murmur ❑ High Blood Pressure ❑ Rheumatic Heart Disease
❑ Heart Attack ❑ Pacemaker ❑ Artificial Heart Valves
❑ Angina ❑ Congenital Defect ❑ Shortness of Breath
❑ Abnormal Bleeding ❑ Other Cardiac _____
❑ Asthma
❑ Diabetes ❑ Type 1 ❑ Type 2
❑ Seizures ❑ Fainting ❑ Stroke ❑ Vertigo
❑ Hepatitis, Liver Disease ❑ Kidney Problems ❑ Thyroid Problems
❑ Respiratory Problems ❑ Tuberculosis ❑ Immune System
❑ HIV or AIDS ❑ Glaucoma ❑ Mental Health Issues
❑ Joint Pain _____

Allergies

❑ Penicillin ❑ Amoxicillin ❑ Tetracycline
❑ Aspirin ❑ Ibuprofen ❑ Codeine, Narcotic
❑ Latex ❑ Food Allergy_____ ❑ Other Allergy _____
❑ Tobacco Use: ❑ Smoke ❑ Oral
❑ Cancer: Date_____ Type_____
Other Medical Conditions_____
_____

Women

❑ Pregnant ❑ Nursing ❑ Birth Control Pills

Office Use Only
❑ Premedicate

- OVER -

DENTAL HISTORY

Chief Dental Concern _____

Any Bad Dental Experiences _____

Check All That Apply:

❑ Snoring ❑ Sleep Apnea ❑ Cold Sores
❑ Jaw Pain ❑ Morning headaches ❑ Facial/Head Trauma

Are Interested in Changing:

❑ Your Smile ❑ Tooth Color/Whiteness ❑ Silver Fillings
❑ Shape of Teeth ❑ Position of Teeth ❑ Spaces Between Teeth

AS A FAMILY PRACTICE WE HAVE YEARS OF EXPERIENCE AND LOVE TO TREAT CHILDREN

Payment is due at time of treatment unless prior arrangements have been made.

Balances over ninety days are subject to 12% financing charge.

As part of our financial policy, should your account be turned over to a collection service, monies incurred to this practice will be the responsibility of the patient to remain in good standing with our practice.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature of Patient: _____

PLEASE VISIT OUR WEBSITE AT www.NewSmilesHappen.com

Medical History Update

Date	Comments	Signature