Medical & Dental History

saving smiles DENTISTRY

Name: _____ Date: _____

Physician's Name: _____ Date of Last Physical: _____

Medication List: (Please fill in or provide a current medication list including vitamins and supplements.)

_____

_____

_____

_____

Do you take blood thinners? ____ Yes ____ No

Have you ever been told to take a pre-med or antibiotics before dental treatment? ____ Yes ____ No

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?

____ Yes ____ No If yes, what? _____

Do you have any drug or food allergies or have you ever had an adverse reaction to medication?

____ Yes ____ No If yes, what? _____

Have you had any surgeries in the last 24 months? ____ Yes ____ No

If yes, what? _____

Have you ever had or been told you have any of the following? (Check all that apply)

_____ Heart Problems	_____ Heart Attack/Failure	_____ Liver Problems
_____ Immune System Problems	_____ Kidney Problems	_____ Tuberculosis
_____ Sinus Problems	_____ Acid Reflux/GERD	_____ Stomach Ulcer/Hyperacidity
_____ Excessive Bleeding	_____ Alzheimer's Disease	_____ Radiation Treatment
_____ Circulation Problems	_____ Epilepsy	_____ Breathing Problems/COPD
_____ Cardiac Pacemaker	_____ Osteoporosis	_____ Chemical Dependency
_____ High Blood Pressure	_____ Back Problems	_____ Tobacco Use
_____ Parkinson's Disease	_____ Artificial Joints	_____ Eating Disorder
_____ Diabetes	_____ Hepatitis	_____ Psychiatric Care
_____ Stroke	_____ AIDS/HIV	_____ Anxiety Disorder

_____ Cancer (site) _____

Do you have any medical disease, condition or problem not listed above that we should know about?

_____

_____

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Do you have any immediate family members with any of the following?

_____ Diabetes _____ Heart Disease/Stroke _____ High Cholesterol

_____ Arthritis _____ Periodontal Disease _____ Cancer (site)_____

Females: Are you pregnant? ____ Yes ____ No

Nursing? ____ Yes ____ No

Use Birth Control? ____ Yes ____ No

Date of Last Dental Exam: _____

Have you ever responded adversely to dental treatment? ____ Yes ____ No

If yes, what? _____

Have you ever had or been told you have any of the following? (Check all that apply)

_____ Bad Breath _____ Clicking/Jaw Pain/TMD _____ Head/Neck/Jaw Injuries

_____ Bad Taste _____ Dentures/Partials _____ Loose Teeth

_____ Biting Pain _____ Difficulty Opening/Closing _____ Lumps/Sores in/near Mouth

_____ Bleeding Gums _____ Dry Mouth _____ Orthodontic Treatment

_____ Chipped Teeth _____ Grinding/Clenching Teeth _____ Periodontal Treatment

_____ Sleep Apnea _____ Sensitive to Hot/Cold _____ Recent Mouth Trauma

Do you have any dental disease, condition or problem not listed above that we should know about?

_____

_____

Have you ever done a sleep study or been diagnosed with sleep apnea? _____

Do you wear a c-pap machine or oral sleep appliance? _____

Are you having pain or discomfort at this time? _____

Are you satisfied with the appearance of your teeth/smile? _____

What is the primary reason for your visit today? _____

The above information is accurate and complete to the best of my knowledge and is only for the use in my treatment, billing and processing of insurance benefits for which I am entitled. I will not hold Saving Smiles Dentistry responsible for any errors or omissions that I may have made in the completion of this form.

Signature: _____ Date: _____