Family, Cosmetic & Implant Dentistry
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MEDICAL/DENTAL HISTORY

Date: ____________________

Name: ______________________________ Cell Phone #: ______________

Address: ______________________________ Home Phone #: ______________

City: ______________________________ State: ______ Zip Code: ________

Email: ______________________________

Social Security Number: ______________ Date of Birth: __________ Sex: ☐ M ☐ F

Height: ________ Weight: ________

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Person to contact in an emergency: ______________________ Phone: ______________

Who may we thank for referring you to our office? ______________________

Employer: ______________________________ Phone: ______________

Address: ______________________________

City: ______________________________ State: ______ Zip Code: ________

Dental Insurance (primary): ______________________________

Group #: ______________________ ID #: ______________________

Dental Insurance (secondary): ______________________________

Group #: ______________________ ID #: ______________________

If you are completing this form for another person what is your relationship? ______________

1. Are you in good health? ______________________________
2. Have there been any changes in your health within the past year? ______________________________
3. Are you now under the care of a physician? __________ Why? ______________
4. Physician: name, phone: ______________________________
5. Any serious illness or hospitalizations within past 5 years? ______________
6. Please list all medications that you take: ______________________________
7. Have you ever had any of the following?

Damaged Heart Valve	☐ Y ☐ N	Heart Murmur	☐ Y ☐ N
Rheumatic Fever	☐ Y ☐ N	Cardiovascular Prob.	☐ Y ☐ N
High Blood Pressure	☐ Y ☐ N	Heart Attack	☐ Y ☐ N
Allergies	☐ Y ☐ N	Asthma	☐ Y ☐ N
Seizures or fainting	☐ Y ☐ N	Diabetes	☐ Y ☐ N
Sexually transmitted disease	☐ Y ☐ N	AIDS or HIV	☐ Y ☐ N
Thyroid problem	☐ Y ☐ N	Breathing problem	☐ Y ☐ N

7. Have you ever had any of the following? *(cont.)*

Persistent cough	☐ Y ☐ N	Swollen glands	☐ Y ☐ N
Cancer	☐ Y ☐ N	Psychological prob.	☐ Y ☐ N
Abnormal Bleeding	☐ Y ☐ N	Blood transfusion	☐ Y ☐ N
Anemia	☐ Y ☐ N	Low Blood Pressure	☐ Y ☐ N

8. Are you allergic to any medications? ______________________
9. Have you had any serious problems with any dental treatment? ______________________
10. Is there any problem not listed that you think is important to discuss? ______________________

Women

1. Are you pregnant? ______________________
2. Are you presently nursing? ______________________
3. Do you take birth control pills? ______________________

Dental History

1. Do your gums bleed? ______________________
2. Do you have bad breath or a stale taste in your mouth? ______________________
3. Do you have any loose teeth? ______________________
4. Are there cosmetic improvements that you would like to make? ______________________
5. Do you want to be asleep for your dental treatment? ______________________
6. Do you have difficulty chewing? ______________________
7. Have you ever been diagnosed with gum disease? ______________________
8. Do you any particular concerns about your dental health? ______________________

Please describe in detail your primary dental concerns and questions: ______________________

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 the dentist, or any other member of the dental staff, responsible for any errors or omissions that I may have made in the completion of this form.

______________________ ______________________

Signature of Patient or Guardian Date