WHITNEY YOUNG HEALTHCARE DESIGNED AROUND HEALTH

Dental Services

WMY I.D# _____ Date _____

Name _____
last first middle

Date of Birth _____ Male _____ Female _____

In Case of Emergency Notify _____ _____
name telephone number

If you are completing this form for another person, what is your relationship to that person? _____

For the following questions, please check ✓**(YES / NO)** whichever applies. Your answers are for our records only and will be considered confidential.

MEDICAL HISTORY

YES / NO

☐ ☐ **1.** The Name, telephone number and address of your **Medical Provider:** _____

_____

When was your last physical exam? _____

☐ ☐ **2.** Are you taking any medications?
If yes, list all medications you currently take **on the back of this form** (this includes all prescription, over the counter and herbal) and the reason you for taking them…

☐ ☐ **3.** Are you allergic to any medications? - *if yes*, please note**:** _____

_____

4. Do you have or have you had any of the following diseases and/or conditions?

YES / NO

☐ ☐ High blood pressure
☐ ☐ Heart murmur / Mitral Valve prolapse
☐ ☐ Rheumatic heart disease
☐ ☐ Congenital heart disease
☐ ☐ Heart attack - *if yes*, when?
_____
☐ ☐ Stroke - *if yes*, when?
_____
☐ ☐ Stents / Shunts
☐ ☐ Cardiac Pacemaker
☐ ☐ Joint replacement (knee, hip, etc.)
☐ ☐ Diabetes
☐ ☐ Thyroid condition
☐ ☐ Arthritis
☐ ☐ Asthma / COPD
☐ ☐ Tuberculosis
☐ ☐ Stomach ulcers or GERD
☐ ☐ Epilepsy / Seizures

YES / NO

☐ ☐ Allergies - *if yes*, to what?
_____
_____
☐ ☐ History of alcohol or drug abuse
☐ ☐ History of tobacco use - *if yes*,
# of years _____
current / former
cigarette / cigar / pipe / chewing tobacco
☐ ☐ Cancer - *if yes*, Radiation or Chemotherapy?
When? _____
☐ ☐ HIV / AIDS
☐ ☐ Lupus
☐ ☐ Blood / Bleeding disorder
☐ ☐ Abnormal bleeding associated with previous extractions, surgery or trauma- *if yes, when*?
_____
☐ ☐ Hepatitis, Liver disease, Cirrhosis
☐ ☐ Kidney Disease / Dialysis
☐ ☐ **(WOMEN)** Are you pregnant / breastfeeding

☐ ☐ **5.** Do have any disease, condition or problem not listed above that you think we should know about**:**
_____

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

X_____ **X**_____
Signature of **patient** (**parent** / legal guardian if minor) **Date** Signature of Dental **Staff** Member **Date**

<< PLEASE TURN OVER >>

Name _____

Date of Birth _____

Medication Name & Dosage	Reason Taking It

DENTAL HISTORY

6. What are your current dental concerns? _____

_____

7. When was the last time you were seen by a dentist? _____

8. Do you <u>have or</u> have you <u>had</u> any of the following:

YES / NO

☐..... ☐..... Sensitive teeth to hot or cold

☐..... ☐..... Oral Habits (fingernail or cheek biting, etc.)

☐..... ☐..... Injury to your face or teeth

☐..... ☐..... Bleeding gums when brushing / flossing

☐..... ☐..... **(CHILDREN)** Do you give your child bottles with sweetened liquid this includes milk, formula and fruit juice?

☐..... ☐..... Does your child take fluoride supplements?

9. How often do you**:**

Brush? _____

Floss? _____

Eat or drink sugary substances? _____