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:** ____________

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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______________________________
Signature of **patient** (**parent** / legal guardian if minor) **Date**

X______________________________
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 have or have you had 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

9. How often do you**:**

Brush? ___________________

Floss? ___________________

Eat or drink sugary substances? ____________

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

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