

MEDICAL HISTORY

Patient Name: _____ **Birthdate:** _____

Are you presently under a physician's care? ____ Physician's Name: _____ Reason: _____

Have you been hospitalized or had a major operation? ____ For what condition? _____

Are you taking any medications, pills or drugs? ____ Please List: _____

Are you allergic to any medications or substances? _____ Please Check: ____ Aspirin; ____ Penicillin; ____ Codeine; ____ Acrylic; ____ Metal; ____ Latex Rubber; ____ Other (please list) _____

WOMEN (please check): ____ Pregnant/Trying to get pregnant; ____ Nursing; ____ Taking Oral Contraceptives

Please Check Yes or No:

	Yes	No		Yes	No		Yes	No		Yes	No
Heart Disease	__	__	Sickle Cell Disease	__	__	Ulcers	__	__	Cold Sores	__	__
Heart Murmur*	__	__	Hemophilia	__	__	Weight Loss	__	__	Herpes	__	__
Irregular Heartbeat	__	__	Leukemia	__	__	Diabetes	__	__	Stroke	__	__
Angina/Chest Pain	__	__	Swelling of Limbs	__	__	Hypoglycemia	__	__	Convulsions	__	__
Heart Attack	__	__	Lung Disease	__	__	Liver Disease	__	__	Epilepsy/Seizures	__	__
Mitral Valve Prolapse *	__	__	Breathing Problem	__	__	Hepatitis A	__	__	Fainting/Dizziness	__	__
Scarlet Fever	__	__	Frequent Cough	__	__	Hepatitis B or C	__	__	Glaucoma	__	__
Rheumatic Fever*	__	__	Hay Fever	__	__	Kidney Trouble	__	__	Tumors/Growths	__	__
Artificial Heart Valve*	__	__	Sinus Trouble	__	__	Renal Dialysis	__	__	Nervousness	__	__
Pace Maker	__	__	Asthma	__	__	Thyroid Disease	__	__	Psychiatric Care	__	__
Heart Surgery*	__	__	Emphysema	__	__	Arthritis/Gout	__	__	Alzheimer's Disease	__	__
High Blood Pressure	__	__	Tuberculosis	__	__	Rheumatoid	__	__	Anesthetic Reaction	__	__
Low Blood Pressure	__	__	Cancer	__	__	Arthritis	__	__	Allergies(Medicines)	__	__
Blood Disease	__	__	Radiation Tx	__	__	Jaw Pain	__	__	Allergies(Pollens)	__	__
Bruise Easily	__	__	Chemotherapy	__	__	Cortisone Tx	__	__	Hives/Rashes	__	__
Anemia	__	__	Stomach/Intestinal	__	__	Artificial Joint*	__	__			
Excessive Bleeding	__	__	Disease	__	__	HIV Positive	__	__			

*if Yes to any of the starred conditions, please call prior to your appointment - Pre-medications may be required.

Do you have any other condition you would like us to know about? ____ Yes ____ No

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and staff at the next appointment without fail.

 PATIENT SIGNATURE (PARENT OR GUARDIAN) _____ DATE _____

Doctor Signature _____ Date _____ BP _____ Pulse _____

MEDICAL UPDATES

I have read my Medical History dated _____ and confirm that it adequately states past and present conditions.

DATE	ADDITIONS	SIGNATURE	BP	Reviewed by
_____	NONE	_____	_____	_____
_____	NONE	_____	_____	_____
_____	NONE	_____	_____	_____
_____	NONE	_____	_____	_____

PATIENT INFORMATION

Patient's Name: _____ Date: _____

Address: _____
street city state zip

Home Phone: _____ Birthdate: _____ Social Security # _____

If patient is a minor, give parent's or guardian's name: _____

Whom may we thank for referring you to our office? _____

Person responsible for Account, if different than above: _____

Address: _____
street city state zip

How long at this Address: _____ Home Phone: _____ Work Phone: _____

Social Security #: _____ Birthdate: _____ Relationship to Patient: _____

Employer: _____ Occupation: _____ Years Employed: _____

Spouse's Name: _____ Birthdate: _____ Social Security #: _____

Employer: _____ Occupation: _____ Work Phone: _____

INSURANCE INFORMATION

Insured's Name: _____ Insured's Social Security #: _____

Insurance Company: _____ Group #: _____ ID #: _____

Insurance Co. Address: _____ Phone #: _____

Do you have Dual Coverage? Yes No If yes:

Insured's Name: _____ Insured's Social Security #: _____

Insurance Company: _____ Group #: _____ ID #: _____

Insurance Co. Address: _____ Phone #: _____

EMERGENCY INFORMATION

Name of nearest relative not living with you: _____ Phone Number: _____

Address: _____

I hereby authorize payment directly to Mike Martin, DDS, of the insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the dental office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I acknowledge the opportunity to review this office's privacy policy. The information on this page is correct to my knowledge.

Signature: (Parent's signature if minor): _____

DENTAL HISTORY

Name: _____

Yes No Please mark yes or no to the following questions:

- ___ ___ Do your gums bleed when brushing, flossing, or eating?
- ___ ___ Do you have difficulty brushing or flossing an area?
- ___ ___ Does food collect between your teeth?
- ___ ___ Do you have a bad taste or odor in your mouth?
- ___ ___ Do you have any loose teeth, or have any teeth moved or shifted in the past two years?
- ___ ___ Do you or have you ever smoked? (packs/day___) (when did you quit?___)
- ___ ___ Have you ever been diagnosed or treated for periodontal disease?
- ___ ___ Do you have any family history of periodontal disease?
- ___ ___ Do you neglect flossing your teeth?

- ___ ___ Do you have toothaches, sore teeth, or dental pain?
- ___ ___ Are your teeth sensitive to hot, cold, sweets, biting, or touch?
- ___ ___ Do you have any broken teeth, missing fillings, or root canals?
- ___ ___ Do you have a dry mouth?
- ___ ___ Are you lacking fluoridated water or fluoride supplements?
- ___ ___ Have you had cavities diagnosed or treated within the last two years?
- ___ ___ Have you ever had a dental implant?

- ___ ___ Do you clench or grind your teeth? Are you awake or asleep when it occurs?
- ___ ___ Do you have soreness or pain in your jaw, ear, or side of your face?
- ___ ___ Do you get frequent headaches?
- ___ ___ Does your jaw ever pop, click, lock, or become fatigued or tired?
- ___ ___ Do you have difficulty opening, closing, or chewing certain types of foods?
- ___ ___ Do your teeth come together unevenly?
- ___ ___ Do you hit one tooth before the others when you bite?
- ___ ___ Do you wear a splint, biteguard, or had an injury to the head/neck, or had an auto accident?

- ___ ___ Are you dissatisfied with the appearance of your teeth?
- ___ ___ Do you dislike the color of your teeth or have noticeable spots or stains?
- ___ ___ Do you have existing crowns or dental work which you consider "ugly"?
- ___ ___ Do you have chips, spaces, crowded or crooked teeth that bother you?
- ___ ___ Are you self-conscious of your teeth or smile?
- ___ ___ Has anyone suggested you change your smile?
- ___ ___ Would you like to improve your smile?

- ___ ___ Have you ever had any complications from past dental treatment?
- ___ ___ Have you ever experienced any complications or reactions from local anesthetic?
- ___ ___ Have you ever had teeth extracted?
- ___ ___ Did you ever have braces or orthodontic treatment?
- ___ ___ Do you have any lumps, sores, or growths in your mouth?
- ___ ___ Does dental treatment cause you much worry or concern?
- ___ ___ Have you ever had an unpleasant dental experience in the past?
- ___ ___ Do you think your teeth are effecting your general health?

Signature _____
 Date _____