

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 Disease	__	__	Artificial Joint*	__	__			
Excessive Bleeding	__	__				HIV Positive	__	__			

*if answered 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

If yes please describe: _____

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 medications change, I shall inform the dentist and staff at the next appointment without fail.

PATIENT SIGNATURE (PARENT OR GUARDIAN)

DATE

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 affecting your general health?

Signature _____ Date _____

Patient Information

Patient's Name: _____ Preferred Name: _____ Date: _____

Address: _____
street city state zip

Please provide all contact information, and then check best method of contact during working hours:

Home Phone: _____ Cell Phone: _____
 Work Phone: _____ E-Mail Address: _____

Birthdate: _____ Social Security # _____ How long at this Address: _____

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

Do other members of your family come here? _____

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

Person responsible for Account, if different than above: _____

Address: _____
street city state zip

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

Employer: _____ Occupation: _____ Years Employed: _____

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

Employer: _____ Occupation: _____ Work Phone: _____

Dental Insurance Information

Employer Name: _____ Insured's Name: _____

Insured's Social Security #: _____ Insured's Birth date: _____

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): _____