Medical/Dental History

Patient Name | Date of Birth

Address | City | Postal Code | Gender: Male Female

Phone | Mobile Phone | Preferred method of contact? Phone SMS Email

Adult Patient

Occupation | Marital Status: M S D W

Employer | Phone (work)

Insurance Company

Plan Number | ID Number

How did you find about us?

Child Patient

Mother's name

Mother's employer | Mother's phone (work)

Father's name

Father's employer | Father's phone (work)

Person responsible for account

1. Have you been under the care of a medical doctor during the past two years? Yes No

If yes, for what?

Physician's name | Physician's phone

2. Have you taken any medication drugs (prescription, recreational or supplements) now or during the past two years? Yes No

If yes, please list the name and dosage

3. Are you aware of having an allergic (or adverse) reaction to any medication or substance? Yes No

If yes, please list

4. Have you been hospitalized in the past five years? ○ Yes ○ No

5. Do you smoke or chew tobacco? ○ Yes ○ No

6. Do you have / wear snore guard, CPAP Machine or nightguard? ○ Yes ○ No

7. Indicate which of the following you have had, or presently have

- ☐ Heart (Surgery, Disease, Attack)
- ☐ Heart Murmur
- ☐ Mitral Valve Prolapse
- ☐ Arthritis / Rheumatism
- ☐ Stroke
- ☐ Kidney Trouble
- ☐ Diabetes
- ☐ Emphysema
- ☐ Asthma
- ☐ Sinus Trouble
- ☐ Tumors
- ☐ Liver Disease
- ☐ A.I.D.S.
- ☐ Blood Transfusion
- ☐ Bruise Easily
- ☐ Fainting or Dizzy Spells
- ☐ Have you ever taken penicillin?
- ☐ Jaw Surgery
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Heart Pacemaker
- ☐ Cortisone Medicine
- ☐ Diet (Special / Restricted)
- ☐ Latex Sensitivity
- ☐ Thyroid Problems
- ☐ Chronic Cough
- ☐ Hay Fever
- ☐ Radiation Therapy
- ☐ Sleep Apnea
- ☐ Yellow Jaundice
- ☐ H.I.V. Positive
- ☐ Hemophilia
- ☐ Neurological Disorders
- ☐ Nervous / Anxious
- ☐ Excessive bleeding
- ☐ Have you been advised to take antibiotics prior to dental treatment?
- ☐ Congenital Heart Disease
- ☐ Artificial Heart Valve
- ☐ Rheumatic Fever
- ☐ Swollen Ankles
- ☐ Artificial Joints (hip, knee etc.)
- ☐ Stomach Ulcers
- ☐ Glaucoma
- ☐ Tuberculosis
- ☐ Allergies or Hives
- ☐ Chemotherapy
- ☐ Hepatitis
- ☐ Venereal Disease
- ☐ Cold Sores / Fever Blisters
- ☐ Sickle Cell Disease
- ☐ Epilepsy or Seizures
- ☐ Psychiatric / Psychological Care
- ☐ Issues with Tonsils or Adenoids?

8. Have you had or do you have any medical condition not listed? ○ Yes ○ No

If yes, please list

9. Have you had orthodontic treatments ○ Yes ○ No

If yes, when? Length of treatment

10. Women

Are you pregnant?

○ Yes ○ No

Are you nursing?

Yes No

Are you taking birth control pills?

Yes No

Are you using a hormone releasing IUD?

Yes No

First & Last Name

Email Address

Signature

X