DENTAL MEDICAL HISTORY FORM

Patient Identification

Full Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____ Email: _____

Emergency Contact

Name: _____ Relationship: _____

Phone Number: _____

Medical History

- ■ Do you have any allergies to medications, latex, or other substances?
- ■ Are you currently under a physician's care?
- ■ Do you take any medications, including over-the-counter or herbal supplements?
- ■ Have you ever been hospitalized or had a major operation?
- ■ Do you have or have you had any of the following? (Check all that apply):
  - ■ Heart disease
  - ■ High blood pressure
  - ■ Diabetes
  - ■ Asthma
  - ■ Thyroid problems
  - ■ Bleeding problems
  - ■ HIV/AIDS
  - ■ Hepatitis
  - ■ Cancer
  - ■ Tuberculosis
  - ■ Other (please specify): _____

Dental History

Date of last dental visit: _____

Have you ever had any unpleasant dental experiences? ■ Yes ■ No

Do you have any current dental pain or discomfort? ■ Yes ■ No

Do your gums bleed or hurt? ■ Yes ■ No

Do you have frequent headaches, earaches or neck pain? ■ Yes ■ No

Do you grind your teeth or clench your jaw? ■ Yes ■ No

Do you wear dentures, partials or orthodontic appliances? ■ Yes ■ No

Have you ever been treated for gum disease or gum surgery? ■ Yes ■ No

Lifestyle and Habits

Do you smoke or use tobacco products? ■ Yes ■ No

Do you consume alcohol? ■ Yes ■ No

Do you use recreational drugs? ■ Yes ■ No

Consent and Authorization

I certify that the above information is true and correct to the best of my knowledge. I authorize the dental office to perform necessary dental treatment and procedures, including the use of anesthetics, and to release any information required for insurance purposes. I understand that I am responsible for payment of all services rendered.

Signature of Patient or Legal Guardian:

_____

Print Name: _____ Relationship to Patient (if Legal Guardian):

Date: _____

For Dental Office Use Only

Provider Name: _____ License Number: _____

Provider Signature: _____ Date: _____

HIPAA Acknowledgement and Privacy Practices

I acknowledge that I have received and reviewed the Notice of Privacy Practices from this dental office. I understand my rights regarding the protection of my health information under the Health Insurance Portability and Accountability Act (HIPAA).

Patient Initials: _____

PATIENT SIGNATURE

Signature: _____

DENTAL PROVIDER SIGNATURE

Signature: _____