METROTOWN DENTAL CLINIC

MEDICAL HISTORY

The following information is required to thoroughly diagnose any condition and to give the highest possible standards of professional services. All information will be kept strictly confidential.

Name: _____

Birthdate (MM/DD/YR): _____

Physician's name: _____

Physician's phone number:_____

1. Have you ever had a serious illness or are you under the care of a physician now? . . . . . Yes | No

IF YES: What illness and for how long?

_____

2. If you use any medicine on a regular basis, please list:

_____

_____

3. Have you ever had any of the following:
(Please check if applicable)

- ☐ Gastrointestinal Disease
- ☐ Mental health disorder
- ☐ Rheumatic Fever
- ☐ Chest pain
- ☐ Heart surgery
- ☐ Heart attack
- ☐ Arthritis and joint pain
- ☐ Fainting/ dizzy spells
- ☐ Hepatitis/ Jaundice
- ☐ Cold sores
- ☐ Multiple sclerosis
- ☐ Cancer (Pls specify) _____
- ☐ Stomach ulcer/Acid reflux
- ☐ Eating disorder
- ☐ Sinus problems
- ☐ Pacemaker
- ☐ Heart problems/ Angina
- ☐ High/ Low blood pressure
- ☐ Anemia/ Easily bruising
- ☐ Diabetes
- ☐ Cortisone treatment
- ☐ Back problems
- ☐ Chemotherapy/ Radiation

	Yes	No
Swelling of ankles, feet, hands	○	○
Joint replacement/ implants	○	○
Skin problems/ Hives/ Rashes	○	○
Tuberculosis	○	○
Thyroid Disease . .	○	○
Heart Disease	○	○
Epilepsy.	○	○
Liver Disease	○	○
Kidney Disease . . .	○	○
Stroke	○	○

Other _____

4. Have you experienced any unusual or allergic reaction to any of the following:

	Yes	No
Local Anesthetic. .	○	○
Penicillin	○	○
Sulfonamide (sulfa)	○	○
Any Metals	○	○
Aspirin	○	○
Latex	○	○
Codeine	○	○

Other _____

5.Are you currently on any blood thinners? . . . . Yes | No ○ ○

6. Are you in a high-risk group or have you ever tested positive for:

	Yes	No
Hepatitis	○	○
H.I.V.	○	○

7. Do you or did you in the past receive intravenous or oral bisphosphonates (Fosamax, Actonel, Boniva)? . . Yes | No ○ ○

If yes, for how long? _____

8. Have you ever been told that you need Antibiotics prior to Dental treatments? . . . . . Yes | No ○ ○

9. If there is a history of family disease, what is it?

_____

_ 10. ***For Women:***

	Yes	No
a) Are you pregnant?	○	○
b) Are you nursing?	○	○
c) Are you taking birth control pills?	○	○

11. How did you hear about our office?
(Please check all those apply)

- ☐ Referred by _____
- ☐ Website
- ☐ Other _____

Signature: _____

Date: _____

METROTOWN DENTAL CLINIC

PATIENT DENTAL HISTORY

Reason for this visit: _____
When was your last dental visit: _____ What was done then: _____
Previous Dentist (name and location): _____
Have you had a complete series of dental x-rays taken at your last dentist: _____
How often do you brush your teeth: _____
How often do you floss your teeth: _____
Do you use an electric or manual toothbrush: _____

	Yes	No
Do your gums bleed while brushing or flossing?	○	○
Are your teeth sensitive to hot or cold liquids/foods?	○	○
Do you feel pain in any of your teeth?	○	○
Do you have sores or lumps in or near your mouth?	○	○
Have you had any head, neck or jaw injuries?	○	○
Have you ever experienced any of the following problems in your jaw:		
Clicking	○	○
Pain (joint, ear, side of face)	○	○
Difficulty/ discomfort in opening or closing	○	○
Difficulty/ discomfort in chewing	○	○
Do you have frequent headaches?	○	○
Do you clench or grind your teeth?	○	○
Do you bite your lips or cheeks frequently?	○	○

	Yes	No
Have you noticed any loosening of your teeth?	○	○
Does food tend to get caught in between your teeth?	○	○
Have you ever had a periodontal treatment of your gums?	○	○
Have you ever worn a nightguard or other appliance?	○	○
Have you ever had prolonged bleeding after extractions?	○	○
Have you ever had problems sleeping/breathing or sinus problems?	○	○
Have you ever been told you snore?	○	○
Have you ever been tested or diagnosed with sleep apnea? If so, when? _____	○	○
Do you wear partials or dentures?	○	○
Have you had orthodontic treatment?	○	○

What dental condition concerns you at present? _____
If you could change anything about your smile, what would you change?
_____

Office Financial and Insurance Policies

As a courtesy to our patients, it is our policy to bill dental plans directly. However, patients are advised that they must be aware of the details, limits and time intervals of their insurance, as they are ultimately responsible for all charges incurred.

- Are you aware of the limits and details of your dental benefits policy? . . . . . Yes / No ○ ○

Authorization and release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including diagnosis, the records of examination & treatment rendered to me or my child to third party mayors and/or health practitioner. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered to me or my dependants.

_____ _____
Signature of patient Date