

# PATIENT MEDICAL AND DENTAL HISTORY

<b>Today's Date</b>			
Name		Age	Birthdate
Patient's Address		City, State, Zip	
Social Security No		Home #	Work # Cell #
Weight	Height	Race	Sex Email Address
Employer Name			
Employer Address			
Name Of Insurance		Group Number	
Responsible Party/Insured's Name		Relation to Insured	
Marital Status		Spouse's Name	
Person to Notify in Emergency/Number			
Physician's Name		Physician's Number	
Driver's License Number/State			

## MEDCAL HISTORY

**Please Circle Yes (Y) or No (N) after the following questions:**

- |  |  |
|--|--|
| <p>1. Has there been any change in your general health during the past year?..... Y N</p> <p>2. Are you under a physicians care other than for routine physicals?..... Y N</p> <p>3. Date of last physical _____</p> <p>4. Have you had any serious illness or operations Describe _____ Y N</p> <p>5. Do you have, or have you had:</p> <p style="margin-left: 20px;">a. Rheumatic fever or rheumatic heart disease?. Y N</p> <p style="margin-left: 20px;">b. Heart murmur?..... Y N</p> <p style="margin-left: 20px;">c. Cardiovascular Disease (heart trouble) coronary artery disease, angina, stroke?..... Y N</p> <p style="margin-left: 20px;">d. High blood pressure?..... Y N</p> <p style="margin-left: 20px;">e. Hay fever? ..... Y N</p> <p style="margin-left: 20px;">f. Sinus trouble?..... Y N</p> <p style="margin-left: 20px;">g. Asthma?..... Y N</p> <p style="margin-left: 20px;">h. Hepatitis, Jaundice, Liver Disease?..... Y N</p> <p style="margin-left: 20px;">i. Arthritis?..... Y N</p> <p style="margin-left: 20px;">j. Fainting Spells or Seizures (Epilepsy)?..... Y N</p> <p style="margin-left: 20px;">k. Diabetes?..... Y N</p> <p style="margin-left: 20px;">l. Ulcers?..... Y N</p> <p style="margin-left: 20px;">m. Kidney or Bladder Disease? ..... Y N</p> <p style="margin-left: 20px;">n. Low Blood Pressure?..... Y N</p> <p style="margin-left: 20px;">o. Thyroid Condition? ..... Y N</p> <p style="margin-left: 20px;">p. Anemia or Other Blood Disorder? ..... Y N</p> <p style="margin-left: 20px;">r. Cancer, Chemotherapy, or Radiation? ..... Y N</p> <p style="margin-left: 20px;">s. Artificial Joint/Implants?..... Y N</p> <p style="margin-left: 20px;">t. Emphysema?..... Y N</p> <p style="margin-left: 20px;">u. Tuberculosis?..... Y N</p> <p>6. Do you bruise easily or have prolonged bleeding? Y N</p> | <p>7. Have you ever been hospitalized?..... Y N<br/>Reasons: _____</p> <p>8. Women: Are you pregnant?..... Y N</p> <p>9. Do you have any other condition not listed above that may affect your treatment?... Y N</p> <p>10. Do you smoke? How much?..... Y N</p> <p>11. Are you allergic to or have you had an adverse reaction to:</p> <p style="margin-left: 20px;">a. Antibiotics(penicillin,sulfa,tetracycline) Y N</p> <p style="margin-left: 20px;">b. Sedatives or tranquilizers? ..... Y N</p> <p style="margin-left: 20px;">c. Aspirin? ..... Y N</p> <p style="margin-left: 20px;">d. Codeine or other painkillers? ..... Y N</p> <p style="margin-left: 20px;">e. Iodine? ..... Y N</p> <p style="margin-left: 20px;">f. Other allergies _____</p> <p>12. Do you believe you may be immunosuppressed or HIV positive? Y N</p> <p>13. Are you taking any medication that may affect your immune system? ..... Y N</p> <p>14. Do you have Glaucoma? Y N</p> <p>15. Have you had prolonged fever, coughing blood, or chest pain? ..... Y N</p> <p>16. Are you using any of the following?</p> <p style="margin-left: 20px;">a. Antibiotics or sulfa drugs? ..... Y N</p> <p style="margin-left: 20px;">b. Anticoagulants (blood thinners)? .... Y N</p> <p style="margin-left: 20px;">c. High blood pressure medicines? ..... Y N</p> <p style="margin-left: 20px;">d. Heart medications (Digitalis, Inderal, Nitroglycerin)? ..... Y N</p> <p style="margin-left: 20px;">e. Steroids (Cortisone, etc.)? ..... Y N</p> <p style="margin-left: 20px;">f. Birth Control Pills? ..... Y N</p> <p style="margin-left: 20px;">g. Insulin or diabetic drugs? ..... Y N</p> |
|--|--|

\*List Medications or drugs you are currently taking below:

Medications	Indications	Side Effects

Please Circle Yes (Y) or No (N) after the following questions:

1. Have you ever been diagnosed or treated for Osteoporosis or Osteopenia? ..... Y N
2. Have you ever taken any of these medications?
  - Etdronate (Didronel).....Y N
  - Tiludronate (Skelid).....Y N
  - Alendronate (Fosamax).....Y N
  - Risedronate (Actonel).....Y N
  - Ibandronate (Boniva).....Y N
  - Pamidronate (Aredia).....Y N
  - Zoledronate (Zometa) .....Y N
3. Have you ever received chemotherapy treatment (IV or oral)? ..... Y N

**WOMEN**

4. Have you ever been diagnosed or treated for multiple myeloma or breast cancer? Y N

**MEN**

5. Have you ever been diagnosed or treated for multiple myeloma or prostate cancer? Y N

If you answered yes to any of the above questions, please give your physicians information.

Name and number of Primary MD \_\_\_\_\_

Name and number of Oncologist \_\_\_\_\_

**Dental History**

Please Circle Yes (Y) or No (N) after the following questions:

1. Do you have problems with you TMJ (jaw joints)? ..... Y N
2. Are any of your teeth sensitive to cold, heat, or sweets? ..... Y N
3. Have you had any serious trouble associated with previous treatment? ..... Y N
4. Do your gums bleed when you brush your teeth? ..... Y N
5. Do you have pain in or near your ears? ..... Y N
6. Do you have any injuries or inflamed areas in your mouth? ..... Y N
7. Have you experienced any growths or sore spots in your mouth? ..... Y N
8. Have you ever had Novocaine anesthetic? ..... Y N
9. Any reactions or allergic symptoms to Novocaine? ..... Y N
10. Any difficult extractions in the past? ..... Y N
11. Prolonged bleeding following extractions in the past? ..... Y N
12. Do you have any dental complaints presently? ..... Y N
13. If so specify \_\_\_\_\_
14. When was your last full dental examination? \_\_\_\_\_
15. When was your last full mouth x-ray taken? \_\_\_\_\_
16. When was your last dental cleaning? \_\_\_\_\_

**Responsible Party**

I am aware that payment is due at the time of service and methods of payment include Cash, Check, Mastercard, Visa and Discover.

I hereby certify that the above information is true and in addition authorize Exact Dentistry, PA, and staff under his direction to perform dental/oral surgical procedures to restore and/or preserve my overall dental/oral health. I am aware that if I do not give a 24-hour notice of cancellation I will be charged a \$20.00 per half hour fee.

\_\_\_\_\_  
Signature (patient or parent if minor) \_\_\_\_\_  
Date

**For Doctor's Use Only**

EVALUATION OF MEDICAL HISTORY

Date	Signature	Assessment/Reassessment

Medical Consultation Required  Yes  No

Consultation received  Yes  No



## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**\*\*You May Refuse to Sign This Acknowledgement\*\***

I, \_\_\_\_\_, have reviewed a copy of this office's Notice of Privacy Practices and aware that the office has a copy of the Notice available to take with me if I request one.

\_\_\_\_\_  
{Please Print Name} PATIENT(18yrs+)/GUARDIAN

\_\_\_\_\_  
{Signature}

\_\_\_\_\_  
{Date}

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### For Office Use Only

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We attempted to obtain written proof of Informed Acknowledgement of Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
  - Communications barriers prohibited obtaining the acknowledgement
  - An emergency situation prevented us from obtaining acknowledgement
  - Other (Please Specify)
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