Patient Medical History

PHYSICIAN'S NAME _____ LAST PHYSICAL DATE _____
PHYSICIAN'S PHONE NUMBER _____
ARE YOU UNDER THE CARE OF A PHYSICIAN NOW? YES / NO
HAVE YOU EVER BEEN HOSPITALIZED FOR ILLNESS OR INJURY? _____
DO YOU TAKE ANY MEDICATIONS? IF SO, PLEASE LIST_____
_____
ARE YOU ALLERGIC TO ANY MEDICATIONS? YES / NO IF YES, PLEASE LIST
_____
DO YOU HAVE ANY OTHER SENSITIVITIES / ALLERGIES?
_____

DO YOU SMOKE? YES / NO CIGARETTES _____ CIGARS _____

DENTAL HISTORY

WHAT IS YOUR REASON FOR YOUR VISIT TODAY?
_____

___ YES ___ NO DO YOU FLOSS DAILY?
___ YES ___ NO DO YOUR GUMS BLEED?
___ YES ___ NO ARE YOUR TEETH SENSITIVE TO SWEET / SOUR / HOT / COLD?(PLEASE CIRCLE)
___ YES ___ NO HAVE YOU HAD ANY HEAD, NECK, OR JAW INJURIES? EXPLAIN
_____
___ YES ___ NO DO YOU WAKE WITH FREQUENT HEADACHES?
___ YES ___ NO ARE YOU AWARE OF CLENCHING OR GRINDING YOUR TEETH?
___ YES ___ NO HAVE YOU EVER HAD ORTHODONTIC (BRACES) WORK?
___ YES ___ NO DO YOU FREQUENTLY BITE YOUR LIPS OR CHEEK?

DO YOU EVER EXPERIENCE ANY OF THE FOLLOWING?
___ JAW CLICKING OR POPPING? ____ PAIN IN THE EAR, JAW, OR SIDE OF FACE?
___ DIFFICULTY OPENING MOUTH? ____ SEVERE HEADACHES OR NECK ACHES**?**

MEDICAL CONDITION

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY)
__ DIABETES
__ HIGH BLOOD PRESSURE
__ HEART PROBLEMS
__ BLOOD DISORDERS
__ RESPIRATORY PROBLEMS
__ CANCER
__ SEIZURES/EPILEPSY
__ LIVER DISEASE/ HEPATITIS A B C
__ KIDNEY DISEASE
__ EYE PROBLEMS (OTHER THAN CORRECTIVE LENSES)
__ ENVIRONMENTAL ALLERGIES _____
__ ADVERSE REACTION TO ANY MEDICATION, PLEASE SPECIFY _____
__ HIV/AIDS
__ SEXUALLY TRANSMITTED DISEASE _____
__ JOINT REPLACEMENT, WHEN? _____
__ LATEX ALLERGY
__ HEARING PROBLEMS

I certify that I have answered all questions accurately to the best of my knowledge and understand that providing false information can be dangerous to my health. I authorize Island Dental Health to release my record of treatment (as necessary) to my dental benefit company and/or other health care practitioners. I understand my dental benefit carrier may pay than the actual bill for services and I agree to be responsible for payment of all services not covered by my plan.

Signature _____ Date _____