MEDICAL HISTORY

DATE OF LAST PHYSICAL EXAM _____

PHYSICIAN(S) NAME _____ SPECIALIST NAME _____

ADDRESS _____ ADDRESS _____

PHONE NUMBER _____ PHONE NUMBER _____

INDICATE ☑ YES OR ☑ NO IF YOU HAVE OR HAD ANY OF THE FOLLOWING.

YES NO

☐ ☐ 1. Are you in good health?

☐ ☐ 2. Are you now under the care of a physician?
If so, what are the conditions being treated? _____

☐ ☐ 3. Have you had any serious illness, operation, or been hospitalized in the last 5 years?
If so, what was the illness or problem? _____

☐ ☐ 4. Are you taking any medicine(s) including non-prescription medicine?
If so, what medicine(s) are you taking? _____

☐ ☐ 5. Do you have any prosthetic joints? _____ Year placed _____

6. Do you have or have you had any of the following diseases or problems?

☐ ☐ a. Congenital heart disease, rheumatic heart disease, infective endocarditis, prosthetic heart valve, or coronary artery stent

☐ ☐ b. Cardiovascular disease including hypertension, angina, heart attack, cardiac arrhythmia, heart failure, or stroke

☐ ☐ 1. Do you experience fatigue, shortness of breath, or chest pain with moderate physical activity?

☐ ☐ 2. Do you have marked limitation of activity due to fatigue, shortness of breath or chest pain but are comfortable at rest?

☐ ☐ 3. Do you have an implanted pacemaker?

☐ ☐ c. Have you ever had a reaction to local anesthetic (novocaine), penicillin, aspirin, iodine, or any other medicines?

☐ ☐ d. Allergies (environmental, food, metals, jewelry, latex rubber, sunscreen lotions, sulfites or other substances)

☐ ☐ e. Addiction to alcohol or use any of the following: marijuana, opioids, methamphetamines, benzodiazepines, cocaine, "club drugs"

☐ ☐ f. Chronic sinus problems

☐ ☐ g. Obstructive sleep apnea

☐ ☐ h. Asthma or COPD (Chronic bronchitis, emphysema)

☐ ☐ i. Low blood pressure, syncope (fainting)

☐ ☐ j. Thyroid problem: ☐ Hypothyroidism ☐ Hyperthyroidism

☐ ☐ k. Kidney disease

☐ ☐ l. Liver disease, hepatitis, jaundice

☐ ☐ m. Diabetes: ☐ Type I ☐ Type II

☐ ☐ n. Tuberculosis or persistent cough that produces blood

☐ ☐ o. AIDS or HIV infection

☐ ☐ p. Sexually transmitted disease

☐ ☐ q. GERD (Gastroesophageal Reflux Disease), stomach ulcer, colitis, Celiac disease

☐ ☐ r. Dementia, Alzheimer's disease, cognitive disorders

☐ ☐ s. Epilepsy or other neurological disease

☐ ☐ t. Treatment for a growth or cancer

☐ ☐ u. Problems with mental health, anxiety or depression

☐ ☐ v. Blood disorder such as anemia or hemophilia

☐ ☐ w. Abnormal or prolonged bleeding or bruise easily

☐ ☐ x. Gout, systemic lupus erythematosus, Sjögrens syndrome

☐ ☐ y. Rheumatoid arthritis, osteoarthritis, osteopenia, osteoporosis

☐ ☐ z. Have you ever taken medication to prevent bone loss or bone tumors?

☐ ☐ aa. Other medical condition not listed above: _____

☐ ☐ 7. Have you had any serious trouble associated with any previous dental treatment? If so, explain _____

WOMEN

☐ ☐ 8. Are you pregnant? If yes, due date: _____

☐ ☐ 9. Are you nursing?

☐ ☐ 10. Are you taking birth control pills?

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

SIGNATURE OF PATIENT (PARENT, GUARDIAN) _____ **DATE** _____
mo. day yr.

For completion by the dentist:

SIGNIFICANT FINDINGS _____

MEDICAL HISTORY UPDATE:

DATE	COMMENTS	SIGNATURE

MARTIN DENTAL CARE
• TRUSTED & COMFORTABLE •

TODAY'S DATE _____

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive, or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. This information is vital to allow us to provide appropriate care.

PATIENT NAME Last _____ First _____ MI _____ SEX: M F

PATIENT INFORMATION AND HEALTH HISTORY

NAME YOU PREFER TO BE CALLED _____ DOB _____ AGE _____ S.S.# (Required) _____

HOME PHONE _____ CELL _____ E-MAIL ADDRESS (Optional) _____

PATIENT'S HOME ADDRESS Street _____ City _____ State _____ Zip _____

PATIENT EMPLOYED BY _____ OCCUPATION _____

BUSINESS ADDRESS _____ BUSINESS PHONE _____

IF MARRIED, SPOUSE'S NAME _____ OCCUPATION _____

EMPLOYED BY _____ BUSINESS PHONE _____

EMERGENCY CONTACT PERSON _____ RELATIONSHIP _____ PHONE _____

PERSON RESPONSIBLE FOR PAYMENT (IF DIFFERENT THAN ABOVE) _____ S.S.# (Required) _____

ADDRESS Street _____ City _____ State _____ Zip _____ PHONE _____

EMPLOYED BY _____ BUSINESS PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU TO THIS OFFICE? _____

DENTAL INSURANCE COVERAGE (IF ANY) SUBSCRIBER NAME _____ PHONE _____

RELATION TO PATIENT _____ DOB _____ S.S.# OR I.D.# OF SUBSCRIBER (Required) _____

SUBSCRIBER'S ADDRESS Street _____ City _____ State _____ Zip _____

EMPLOYER _____ PHONE _____

PLAN NAME _____ GROUP NO _____

INSURANCE CO _____ YEARLY MAX ALLOWANCE $ _____

CLAIMS ADDRESS Street _____ City _____ State _____ Zip _____

INSURANCE: To avoid any misunderstanding regarding dental insurance, we wish our patients to know that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We will prepare necessary forms or reports to help you obtain and maximize your insurance benefits. We do not render our services on the basis that insurance companies will pay all our fees.

INDICATE ☑ YES OR ☑ NO IF YOU HAVE ANY OF THE FOLLOWING DISEASES OR PROBLEMS:

YES	NO		YES	NO	
☐	☐	Active Tuberculosis	☐	☐	Persistant cough greater than a three week duration
☐	☐	Cough that produces blood	☐	☐	Been exposed to anyone with Tuberculosis

IF YOU ANSWER YES TO ANY OF THE 4 ITEMS ABOVE, PLEASE STOP AND RETURN THIS FORM TO THE RECEPTIONIST.

DENTAL HISTORY

DATE OF LAST DENTAL EXAM _____

WHAT IS THE REASON FOR YOUR VISIT TODAY? (Chief Dental Complaint) _____

INDICATE ☑ YES OR ☑ NO IF YOU HAVE OR HAD ANY OF THE FOLLOWING:

YES	NO		YES	NO	
☐	☐	Injury to your face or jaws	☐	☐	Complications from extractions
☐	☐	Recent pain or tenderness in or about the mouth	☐	☐	Previous periodontal (gum) treatment
☐	☐	Canker or cold sores	☐	☐	Previous orthodontic treatment
☐	☐	Teeth sensitive to cold, hot, sweets, or pressure	☐	☐	Previous treatment for a temporomandibular disorder (TMJ)
☐	☐	Swelling or lumps in the mouth or neck	☐	☐	Do you wear dentures or partials?
☐	☐	Swollen or bleeding gums when brushing or flossing	☐	☐	Do you dislike the appearance of your teeth and your smile?
☐	☐	Bad breath or unpleasant taste	☐	☐	Do you have spaces that you don't like?
☐	☐	Loose teeth	☐	☐	Do you dislike the color of your teeth?
☐	☐	Clench or grind your teeth	☐	☐	Do you dislike the shape or alignment of your teeth?
☐	☐	Smoke cigarettes, pipe, cigar, or chew tobacco	☐	☐	Are there old fillings or dental work that you don't like looking at?
☐	☐	Dry mouth	☐	☐	Do you mostly drink bottled or well water at home?
☐	☐	Food or floss catching between teeth	☐	☐	Do you participate in active recreational activities?

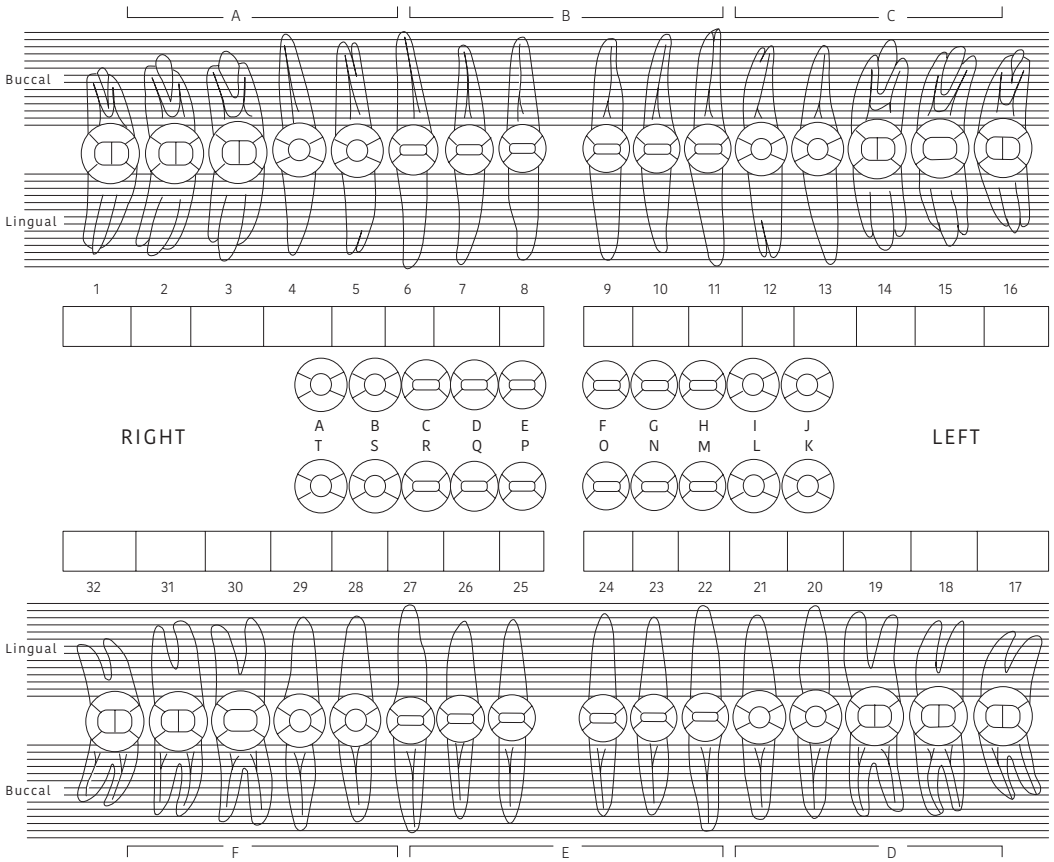
How often do you brush? _____ How often do you floss your teeth? _____

Do you use other home dental care products or techniques? _____

COMMENTS _____

MEDICAL ALERT →

NAME _____



TREATMENT RECOMMENDED

REFERRALS

DATE SPECIALIST

OCCLUSION

DATE	TOOTH	SERVICE RENDERED

NOTES