Hoover Park Dental

Medical History form

In an effort to serve you better, we ask that you complete the following medical form. We will be glad to assist you with any questions you have.

PATIENT INFORMATION

Name **:** _____
First Last
Address **:** _____
Street City Prov Postal Code
Home phone: (_____) _____ Cell: (_____) _____ Work: (_____)_____
Emai **l** : _____ Referral: _____
Date of Birth: _____/_____/_____ (day/mth/yr)
Emergency Contact_____ Tel: (_____) _____
How would you like us to contact you? home / work / cell / email

FINANCIAL INFORMATION

Insurance Company: _____ Employer: _____
Pol #: _____ Cert #: _____ Policy year: _____
% coverage for basic: _____ major: _____
Name of Insured (if different than above):_____
First Last
Address (if different than above) : _____
Street Apt City Prov Postal code
Date of Birth: _____/_____/_____ Tel: (_____) _____ Email: _____

DENTAL HISTORY

1. What is the reason for today's visit? ___ emergency ___ exam ___ other _____
2. How frequently do you see a dentist? ___ 3-6 mons ___ annually ___ other _____
3. When was your last dental visit? _____ Last x-ray? _____
4. How often do you brush per day? _____ Floss? _____ Mouth rinse? _____
5. Are your teeth sensitive to: ___ cold ___ hot ___ sweets ___ other _____
6. Do your gums bleed when ___ brushing ___ flossing ___ never
7. Do your gums feel swollen or tender? YES / NO
8. Do you have bad breath or a bad taste in your mouth? YES / NO
9. Do your jaws crack, pop, or grate when you open wide? YES / NO
10. Do you grind or clench your teeth? YES / NO
11. Do you have food catch between your teeth? YES / NO
12. Have you ever had local anesthetic (freezing)? YES / NO
13. Any complaints? Specify_____
14. Are you satisfied with your teeth? Specify _____
YES / NO
15. Have you ever had any problems with previous dental treatments?
Specify_____
16. Have you ever had any of the following: ___ bridgework ___ crowns/caps ___dentures ___ implant___ root canal ___ periodontal ___ orthodontic

MEDICAL HISTORY

1. Are you presently under the care of a physician? Explain: _____YES / NO
2. Have you ever been hospitalized? Explain: _____ YES / NO
3. Are you taking any drugs or medications at this time? YES / NO

A) Drug: _____ Reason: _____
B) Drug: _____ Reason: _____
C) Drug: _____ Reason: _____

4. Have you ever had an adverse reaction to any of the following: YES / NO

___ Penicillin ___ Sulfonamide ___ Aspirin___ Barbiturates (sleeping pills) ___ Codeine
___ Darvon ___ Local Anesthetic ___ Other ___ None

5. Have you ever been warned against using any other medications? Which? _____ YES / NO
6. Have you ever taken prolonged medical or non-medical drugs? Which? _____YES / NO
7. Do you suffer from any allergies (hay fever, latex, etc)? Which? _____YES / NO
8. Do you bruise easily or have prolonged bleeding? YES / NO
9. Do you smoke? How many per day? _____ YES / NO
10. Have you ever fainted, had shortness of breath, or chest pains? YES / NO
11. Are you pregnant? YES/ NO Using birth control? YES/NO Reached Menopause? YES/NO
12. Do you have, or have you ever had any of the following? Please check appropriate boxes. ___ NONE

__ AIDS __ Glandular Disorders __ Malignant Hypothermia
__ Anemia __ Glaucoma __ Mental/Nervous Disorder
__ Angina Pectoris __ Head/Neck Injuries __ Mitral Valve Prolapse
__ Anorexia Nervosa __ Heart disease/attack __ Organ Transplant/Implant
__ Artificial Heart Valve __ Heart Murmur __ Psychiatric Disorders
__ Arthritis/Rheumatism __ Heart pacemaker/surgery __ Radiation/Chemotherapy
__ Artificial Joints (knees, hips) __Hepatitis A/B/C __ Rheumatic/Scarlet Fever
__ Asthma __ Herpes __ Sickle Cell Disease
__ Blood disorders __ High/Low Blood pressure __ Sinus Trouble
__ Bronchitis __ HIV Positive __ Stomach/Intestinal problems
__ Bulimia __ Hodgkin Disease __ Stroke
__ Cancer __ Hypertension __ Thyroid disease
__ Circulation Problems __ Hyper (hypo) Glycemia __ Tuberculosis
__ Cortisone/Steroid __ Jaundice __ Ulcers
__ Congenital Heart Lesions __ Kidney Disease __ Venereal Disease
__ Diabetes __ Liver Disease __ Other _____
__ Drug/Alcohol Dependence __ Leukemia __ Other _____
__ Emphysema __ Lung Disease __ Other _____

13. **CHILDREN:** Have you recently had any of the following (approximate date)?

___ Chicken Pox _____ ___ Measles _____ ___Mumps _____
___ Strep Throat _____ ___ Tonsillitis _____ ___ None_____

GENERAL RELEASE

I, the undersigned, understand that the information contained in the medical and dental history is important to my treatment. I certify that all of the information I have completed is correct and that I have not knowingly omitted data. I consent to the release of medical information from my medical doctor or other health care provider as is required by this dental office. I authorize this dental office to perform diagnostic procedures as may be required to determine necessary treatment. I understand that it is my responsibility to pay for dental treatment for both myself and my dependants. I assume all responsibility for fees associated with my dental treatment or dental diagnostic procedures.

_____ _____ _____
Signature (patient/guardian) Print Name Date