Patient Information, Medical & Dental History

Welcome! So that we may provide you with the best possible care, please complete both sides of this medical/dental history form. All information is completely confidential.

PATIENT INFORMATION

Name_____ { } Male { } Female Today's Date_____
First MI Last

How do you wish to be addressed by our staff?_____ Date of Birth____/____/____

Whom may we thank for referring you?_____

SSN #_____ Email Address_____

Mailing Address_____ City_____ State_____ Zip_____

Home #_____ Cell #_____ Work #_____

Physician's Name_____ Phone #_____

Do you prefer appointment reminders by: { } Email { } Phone { } Text { } All forms/No preference

Do you prefer to receive calls from our office at: { } Home { } Cell { } Work { } All forms/No preference

Are you: { } Minor { } Married { } Single { } Divorced { } Widowed { } Separated

Employer_____ Occupation_____

Spouse's Name_____ Spouse's Date of Birth____/____/____
First MI Last

Spouse's Employer_____ Spouse's Occupation_____

Spouse's Work #_____ Is the patient a full time student? { } No { } Yes

If yes, name of the school_____

RESPONSIBLE PARTY (only if different than patient)

Name_____ Date of Birth____/____/____
First MI Last

Mailing Address_____ City_____ State_____ Zip_____

Home #_____ Cell #_____ Work #_____

SSN #_____ Relationship_____

INSURANCE INFORMATION

Medical Insurance

Subscriber's Name_____ Date of Birth____/____/____

SSN#_____ Relationship to Patient_____

Insurance Company_____ Policy #_____ Group#_____

Patient Information, Medical & Dental History

All information is completely confidential.

Supplemental Insurance (Dental)

Subscriber's Name_____ Relationship to Patient_____

Mailing Address_____ City_____ State_____ Zip_____

Date of Birth___/___/___ SSN#_____ Employer_____

Insurance Company_____ Group#_____ Effective Date___/___/___

Do you have additional Dental Insurance? { } Yes { } No If yes, please complete the following:

Subscriber's Name_____ Relationship to Patient_____

Mailing Address_____ City_____ State_____ Zip_____

Date of Birth___/___/___ SSN#_____ Employer_____

Insurance Company_____ Group#_____ Effective Date___/___/___

DENTAL HISTORY *– Please fill out the following to the best of your ability*

What is the reason for your visit today? _____

Previous Dentist's Name _____ Telephone _____

Date of last dental visit _____ Last dental cleaning _____ Last X-Rays _____

How often do you have dental examinations? _____ How often do you brush? _____

Have you ever used topical fluoride?_____ How often do you floss? _____

What other dental aids do you use? (Toothpick, etc.) _____

Do you have any dental problems now? _____

Are any of your teeth sensitive to:

Hot or cold?	Y / N
Sweets?	Y / N
Biting or chewing?	Y / N
Have you noticed any bad odors or tastes?	Y / N
Do you frequently get cold sores or blisters?	Y / N
Do your gums hurt or bleed?	Y / N
Have your parents experienced gum disease or tooth loss?	Y / N
Have you noticed loose teeth or change in your bite?	Y / N
Does food tend to become caught in your teeth?	Y / N

If yes, where? _____

Do you:

Clench or grind your teeth?	Y / N
Bite your lips or cheeks regularly?	Y / N
Hold foreign objects with your teeth?	Y / N
Mouth breathe?	Y / N
Have tired jaws, especially in the morning?	Y / N
Snore or have any sleep disorders?	Y / N
Smoke/chew tobacco or other tobacco products?	Y / N

Have you ever had:

Orthodontic treatment?	Y / N
Oral surgery?	Y / N
Periodontal treatment?	Y / N
Your teeth ground or bite adjusted?	Y / N
A bite plate or mouth guard?	Y / N
A serious injury to the mouth or head?	Y / N

If yes, explain _____

Have you experienced:

Clicking or popping of the jaw?	Y / N
Pain? (ear, side of face, joint)	Y / N
Difficulty opening or closing the mouth?	Y / N
Difficulty chewing on either side?	Y / N
Headaches, neck aches, shoulder aches?	Y / N
Sore muscles (neck, shoulders)?	Y / N
Are you satisfied with your teeth's appearance?	Y / N
Would you like to keep your teeth all of your life?	Y / N
Do you feel nervous about having dental treatment?	Y / N

If so, biggest concern? _____

(see other side)

Patient Information, Medical & Dental History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or had, or medication that you may be taking, could have an important interrelationship with the treatment you will receive. Thank you for answering the following questions. All information is completely confidential.

MEDICAL HISTORY – *Please fill out the following to the best of your ability*

Are you under a physician's care now?	Yes	No	If yes, please list the information on the following page.
Have you ever been hospitalized or had a major operation?	Yes	No	If yes, please list the information on the following page.
Have you ever had a serious head or neck injury?	Yes	No	If yes, please list the information on the following page.
Are you currently taking a blood thinner?	Yes	No	If yes, please list the information on the following page.
Have you ever taken Fosamax, Boniva, Actonel?	Yes	No	If yes, please explain:_____
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	If yes, please list the information on the following page.
Are you on a special diet?	Yes	No	If yes, please explain:_____
Do you use tobacco or smoke?	Yes	No	If yes, how often:_____
Do you consume alcoholic beverages?	Yes	No	If yes, how often:_____
Do you use recreational drugs?	Yes	No	If yes, please explain:_____
Do you use controlled substances?	Yes	No	If yes, please explain:_____
Do you need to **pre-medicate**?	Yes	No	If yes, please explain:_____

Women: Are you Pregnant/Trying? { } Yes { } No **Taking Oral Contraceptives?** { } Yes { } No **Nursing?** { } Yes { } No

Are you allergic to any of the following? { } Penicillin { } Latex { } Codeine { } Aspirin { } Acrylic { } Metal
{ } Local Anesthetics { } Other_____ If yes, please explain_____

Do you currently have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Hypoglycemia	Yes	No	Congestion	Yes	No
Alzheimer's Disease	Yes	No	Intestinal Disease	Yes	No	Depression	Yes	No
Anaphylaxis	Yes	No	Irregular Heartbeat	Yes	No	Difficulty Swallowing?	Yes	No
Anemia	Yes	No	Kidney Problems	Yes	No	Dizziness	Yes	No
Angina	Yes	No	Leukemia	Yes	No	Do you wear removable teeth?	Yes	No
Arthritis/Gout	Yes	No	Liver Disease	Yes	No	Dry Mouth	Yes	No
Artificial Heart Valve	Yes	No	Low Blood Pressure	Yes	No	Dysphagia	Yes	No
Artificial Joint	Yes	No	Lung Disease	Yes	No	Ear Pain	Yes	No
Asthma	Yes	No	Mitral Valve Prolapse	Yes	No	Eating Disorders	Yes	No
Blood Disease	Yes	No	Pain in Jaw Joints	Yes	No	Excessive Stress	Yes	No
Blood Transfusion	Yes	No	Parathyroid Disease	Yes	No	Fibromyalgia	Yes	No
Breathing Problem	Yes	No	Psychiatric Care	Yes	No	Frequent Urination	Yes	No
Bruise Easily	Yes	No	Radiation Treatments	Yes	No	GERD	Yes	No
Cancer	Yes	No	Recent Weight Loss	Yes	No	Gout	Yes	No
Chemotherapy	Yes	No	Renal Dialysis	Yes	No	High Cholesterol	Yes	No
Chest Pains	Yes	No	Rheumatic Fever	Yes	No	Hormonal Change	Yes	No
Cold Sores	Yes	No	Rheumatism	Yes	No	Joint Pain	Yes	No
Congenital Heart Disorder	Yes	No	Scarlet Fever	Yes	No	Knee/Hip Replacement	Yes	No
Convulsions	Yes	No	Shingles	Yes	No	Memory Loss	Yes	No
Cortisone Medicine	Yes	No	Sickle Cell Disease	Yes	No	Memory Problems	Yes	No
Diabetes	Yes	No	Sinus Trouble	Yes	No	Multiple Sclerosis (MS)	Yes	No
Drug Addiction	Yes	No	Spina Bifida	Yes	No	Muscle Weakness	Yes	No
Easily Winded	Yes	No	Stroke	Yes	No	Nocturia	Yes	No
Emphysema	Yes	No	Swelling of Limbs	Yes	No	Nose Bleeding	Yes	No
Epilepsy	Yes	No	Thyroid Disease	Yes	No	Pulmonary Embolism	Yes	No
Excessive Bleeding	Yes	No	Tonsillitis	Yes	No	Recent Trauma or Injury	Yes	No
Excessive Thirst	Yes	No	Tuberculosis	Yes	No	Seizures	Yes	No
Fainting/Dizzy Spells	Yes	No	Tumors or Growths	Yes	No	Soft or Special Diet	Yes	No
Frequent Cough	Yes	No	Ulcers	Yes	No	Sulfa Allergy?	Yes	No
Frequent Diarrhea	Yes	No	Venereal Disease	Yes	No	Tachycardia	Yes	No
Frequent Headaches	Yes	No	Yellow Jaundice	Yes	No	Tingling/Numbness	Yes	No
Genital Herpes	Yes	No				Tinnitus (Ringing in Ear)	Yes	No
Glaucoma	Yes	No	**Also, please answer the following...**			Tremor	Yes	No
Hay Fever	Yes	No				Trigeminal Neuralgia	Yes	No
Heart Attack/Failure	Yes	No	Current Weight: _____ lbs.			Wisdom Teeth Extraction?	Yes	No
Heart Murmur	Yes	No	Height: _____ ft. _____ in.					
Heart Pace Maker	Yes	No				Obstructive Sleep Apnea	Yes	No
Heart Trouble/Disease	Yes	No	Acid Reflux	Yes	No	Do you use a CPAP?	Yes	No
Hemophilia	Yes	No	ADD/ADHD	Yes	No	If yes, how often_____		
Hepatitis A	Yes	No	Anxiety	Yes	No	Do you snore?	Yes	No
Hepatitis B or C	Yes	No	Back Pain	Yes	No	Daytime Sleepiness	Yes	No
Herpes	Yes	No	Bronchitis	Yes	No	Fatigue/Tired	Yes	No
High Blood Pressure	Yes	No	Change in Hearing	Yes	No	Morning Headaches	Yes	No
Hives or Rash	Yes	No	Change in Vision	Yes	No	Nasal Obstruction	Yes	No

(see other side)

Patient Information, Medical & Dental History

All information is completely confidential.

List any medications you are currently taking:

	Medication	Reason
1.		
2.		
3.		
4.		
5.		
6.		

List any major surgeries or hospitalizations you have had:

	Date	Surgery
1.		
2.		
3.		
4.		
5.		
6.		

NOTE: If you have a current list, the front desk may make a copy of this for your records

List and detail any medical condition or history not listed above:

Primary Physician's Name_____ Phone #_____

Are you under the care of other physicians? If so, please list:

Physician	Phone #	Reason

GENERAL CONSENT TO DISGNOSE AND TREAT

The undersigned hereby authorizes McMahon Family Dental to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the undersigned patient's dental condition and needs. I authorize McMahon Family Dental to perform any and all forms of treatment, medication, and therapy that may be necessary and further consent that McMahon Family Dental chooses to employ such assistance as deemed necessary. I understand that the use of local anesthetics agents embodies certain risk and consent to their use as deemed appropriate by McMahon Family Dental. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my/the patient's health. **It is my responsibility to inform the dental office of any change in medical health or status.**

CONSENT (ADULT)

Name of Patient_____ Signature of Patient_____ Date_____

CONSENT (FOR A MINOR)

Name of Parent/Guardian_____ Signature of Parent/Guardian_____ Date_____

(see other side)