MEDICAL & DENTAL HISTORY

Because oral health is closely linked to overall health, an accurate and current medical history is an essential tool in providing quality dental care. It can alert us to specific concerns that may impact the delivery of your oral health care.

DENTAL HISTORY:

YOUR NAME:_____ TODAY'S DATE: _____/_____/_____

STREET:_____CITY:_____ST:_____ZIP_____

PHONE #:_____-_____-_____ CELL PH#: _____-_____-_____E-MAIL ADDRESS:_____

ARE YOU UNDER DENTAL CARE ELSEWHERE? (i.e. Summer Dentist / Periodontist / Orthodontist) YES ❑ NO ❑

IF SO, DENTIST'S NAME:_____ PHONE #:_____

STREET:_____CITY:_____ST:_____ZIP_____

HAVE YOU NOTICED:			HAVE YOU HAD ANY OF THE FOLLOWING:		
TIRED JAWS IN THE MORNING	YES ❑	NO ❑	ORTHODONTIC TREATMENT	YES ❑	NO ❑
NECK OR SHOULDER ACHES	YES ❑	NO ❑	ENDODONTIC (ROOT CANAL) TREATMENT	YES ❑	NO ❑
MOUTH ODORS OR BAD TASTES	YES ❑	NO ❑	PERIODONTAL (GUM) TREATMENT	YES ❑	NO ❑
SORES OR LUMPS IN / NEAR YOUR MOUTH	YES ❑	NO ❑	ORAL SURGERY	YES ❑	NO ❑
DRY MOUTH	YES ❑	NO ❑	A BITE PLATE OR MOUTH GUARD	YES ❑	NO ❑

HAVE YOUR PARENTS EXPERIENCED GUM DISEASE OR TOOTH LOSS? YES ❑ NO ❑

ARE YOU INTERESTED IN HAVING YOUR TEETH WHITENED? YES ❑ NO ❑

MEDICAL HISTORY

MEDICAL HISTORY:

PHYSICIAN'S NAME:_____ PHONE NUMBER:_____-_____-_____

HAVE YOU BEEN HOSPITALIZED FOR SURGICAL CARE OR SERIOUS ILLNESS WITHIN THE LAST FIVE (5) YEARS? YES ❑ NO ❑

DO YOU REQUIRE PRE-MEDICATION FOR DENTAL APPOINTMENTS? YES ❑ NO ❑ If YES, name of Rx:_____

ARE YOU TAKING ASPIRIN OR A PRESCRIPTION BLOOD THINNER ? YES ❑ NO ❑

ARE YOU TAKING ANY PRESCRIPTION MEDICATION(S) SUCH AS FOSAMAX FOR OSTEOPOROSIS? YES ❑ NO ❑

ARE YOU TAKING ANY VITAMINS OR NON-PRESCRIPTION MEDICATION FOR OSTEOPOROSIS? YES ❑ NO ❑

NAME OF PHARMACY:_____PHONE #:_____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING (OR ATTACH LIST). PLEASE PROVIDE SPECIFIC DETAILS BELOW:

_____ _____

_____ _____

_____ _____

_____ _____

DO YOU USE TOBACCO? YES ❑ NO ❑ DO YOU USE EXTRA PILLOWS TO SLEEP? YES ❑ NO ❑

DO YOU USE CONTROLLED SUBSTANCES? YES ❑ NO ❑

ARE YOU AWARE OF HAVING HAD AN ADVERSE ALLERGIC REACTION TO ANY OF THE FOLLOWING?

LOCAL ANESTHETICS	YES ❑	NO ❑	SEDATIVES	YES ❑	NO ❑
IODINE	YES ❑	NO ❑	SULFA DRUGS	YES ❑	NO ❑
LATEX RUBBER	YES ❑	NO ❑	ASPIRIN	YES ❑	NO ❑
BARBITURATES	YES ❑	NO ❑	ANTIBIOTICS	YES ❑	NO ❑
METALS (NICKEL, MERCURY, ETC.)	YES ❑	NO ❑	PRESCRIPTION PAIN MEDICATION	YES ❑	NO ❑
ACRYLIC	YES ❑	NO ❑			

IF YES TO ALLERGY TO ANTIBIOTICS, PAIN MEDICATIONS OR OTHER ALLERGIES NOT LISTED ABOVE, PLEASE PROVIDE DETAILS BELOW:

_____

_____

_____

Continued on reverse side ⟶

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

ANEMIA	YES ❑ NO ❑	HEART MURMUR	YES ❑ NO ❑
ANGINA	YES ❑ NO ❑	HEPATITIS/JAUNDICE	YES ❑ NO ❑
ARTHRITIS	YES ❑ NO ❑	HERPES/COLD SORES	YES ❑ NO ❑
ARTIFICIAL HEART VALVE	YES ❑ NO ❑	HIGH BLOOD PRESSURE	YES ❑ NO ❑
ARTIFICIAL JOINTS / JOINT REPLACEMENT	YES ❑ NO ❑	HIV / AIDS	YES ❑ NO ❑
ASTHMA / BRONCHITIS	YES ❑ NO ❑	KIDNEY DISEASE	YES ❑ NO ❑
ATRIAL FIBRILLATION	YES ❑ NO ❑	LEUKEMIA	YES ❑ NO ❑
BLOOD DISORDER OR EXCESSIVE BLEEDING	YES ❑ NO ❑	LIVER DISEASE	YES ❑ NO ❑
BONE INFECTION / DISORDERS	YES ❑ NO ❑	LOW BLOOD PRESSURE	YES ❑ NO ❑
CANCER	YES ❑ NO ❑	MITRAL VALVE PROLAPSE	YES ❑ NO ❑
CHEMOTHERAPY	YES ❑ NO ❑	OSTEOPOROSIS	YES ❑ NO ❑
CHEST PAIN / EASILY WINDED	YES ❑ NO ❑	PACEMAKER	YES ❑ NO ❑
DEMENTIA	YES ❑ NO ❑	PARKINSON'S DISEASE	YES ❑ NO ❑
DIABETES	YES ❑ NO ❑	RADIATION TREATMENT	YES ❑ NO ❑
EMOTIONAL DISTURBANCE / DEPRESSION	YES ❑ NO ❑	RESPIRATORY PROBLEMS	YES ❑ NO ❑
EMPHYSEMA	YES ❑ NO ❑	RHEUMATIC FEVER	YES ❑ NO ❑
EPILEPSY / SEIZURES / CONVULSIONS	YES ❑ NO ❑	SEXUALLY TRANSMITTED DISEASE	YES ❑ NO ❑
FAINTING / DIZZINESS	YES ❑ NO ❑	SINUS ISSUES	YES ❑ NO ❑
GLAUCOMA	YES ❑ NO ❑	STOMACH PROBLEMS / ULCERS / ACID REFLUX	YES ❑ NO ❑
HAY FEVER / ALLERGIES	YES ❑ NO ❑	STROKE	YES ❑ NO ❑
HEARING DIFFICULTY	YES ❑ NO ❑	THYROID DISEASE	YES ❑ NO ❑
HEART DISEASE / HEART ATTACK	YES ❑ NO ❑	TUBERCULOSIS	YES ❑ NO ❑

OTHER CONDITIONS NOT LISTED ABOVE: _____

WOMEN ONLY:

ARE YOU TAKING ORAL CONTRACEPTIVES?	YES ❑ NO ❑	HAVE YOU ENTERED MENOPAUSE?	YES ❑ NO ❑
ARE YOU PREGNANT?	YES ❑ NO ❑	DO YOU TAKE ESTROGEN?	YES ❑ NO ❑
ARE YOU NURSING?	YES ❑ NO ❑	IF SO, WHAT TYPE?	_____

AUTHORIZATION / RELEASE:

ALL EMERGENCY DENTAL SERVICES, OR ANY DENTAL SERVICES, MUST BE PAID FOR AT THE TIME SERVICES ARE PERFORMED. THE PRACTICE DEPENDS UPON REIMBURSEMENT FROM THE PATIENTS FOR THE COSTS INCURRED IN THEIR CARE AND FINANCIAL RESPONSIBILITY ON THE PART OF EACH PATIENT MUST BE DETERMINED BEFORE TREATMENT. PATIENTS WHO CARRY DENTAL INSURANCE UNDERSTAND THAT ALL DENTAL SERVICES ARE, AS A COURTESY, SUBMITTED TO YOUR INSURANCE. THIS DENTAL OFFICE CANNOT RENDER SERVICES ON THE ASSUMPTION THAT OUR CHARGES WILL BE PAID BY AN INSURANCE COMPANY. I UNDERSTAND THAT THE FEE ESTIMATE LISTED FOR THIS DENTAL CARE CAN ONLY BE EXTENDED FOR A PERIOD OF 30-DAYS FROM THE DATE OF THE PATIENT EXAMINATION. IN CONSIDERATION FOR THE PROFESSIONAL SERVICES RENDERED TO ME, OR AT MY REQUEST, BY THE DOCTOR, I AGREE TO PAY THE REASONABLE VALUE OF SERVICES TO THE DOCTOR, OR HIS ASSIGNEE, AT THE TIME SERVICES ARE RENDERED. APPOINTMENTS CHANGED OR RESCHEDULED ON SHORT NOTICE MAY BE SUBJECT TO A MISSED APPOINTMENT FEE. I FURTHER AGREE TO THE FOLLOWING: THAT THE REASONABLE VALUE OF SERVICES SHALL BE PAID UNLESS OBJECTED TO, BY ME, IN WRITING. I WILL NOT HOLD SMILE SARASOTA, MY DENTIST OR ANY MEMBER OF THE STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS IN COMPLETING THIS FORM. I HAVE READ THE ABOVE CONDITIONS OF TREATMENT AND PAYMENT AND AGREE TO THEIR CONTENT.

_____ _____/_____/_____ _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE RELATIONSHIP TO PATIENT

_____ ____/____/____

SIGNATURE OF GUARANTOR OR PAYMENT/RESPONSIBLE PARTY DATE

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have questions at any time, please ask us. We are happy to help!

OFFICE USE ONLY:

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