MIDTOWN
DENTAL SERVICES

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

What is the reason for your visit today? _____

Name _____ Date of Birth _____

Address _____ Social Security Number _____

Home Phone _____ Alternate Phone _____

Email _____

Dentist _____ Town _____

Physician _____ Town _____ Last Physical Exam _____

Occupation/Job Title _____

DENTAL INSURANCE

Insurance Carrier _____ Address _____

Policy Holder _____ Group No. _____

Social Security Number _____ Date of Birth _____

Employer _____ Employer Address _____

DENTAL HEALTH

What do you do at home to take care of your teeth? _____

_____

_____

Is there anything you would like to change about your teeth? _____

_____

_____

Did you or do you happen to smoke or use any form of tobacco? Yes No

If so, how much and for how many years? _____

Do you have a family history of gum disease or early tooth loss? (Grandparents, parents, or siblings) Yes No

Have you ever had:

Braces?	Yes	No
Gum/Periodontal Treatment?	Yes	No
Oral Surgery?	Yes	No
Bite plate, mouth guard or Night Guard?	Yes	No
Trauma or Injury to the mouth or head?	Yes	No

Do you:

Clench or grind your teeth?	Yes	No
Nail biting habit?	Yes	No
Aggressive Brushing Habit?	Yes	No
Joint Pain in your Jaw?	Yes	No
Muscle Pain in your Jaw?	Yes	No

Are any of your teeth sensitive to: (Circle all that apply)

Hot Cold Sweets Biting or Chewing

Do you frequently get cold sores, blisters, or any other oral lesions?	Yes	No
Are you currently experiencing any dental pain?	Yes	No

Is there anything else you would like us to know regarding your past dental treatment? Yes No

If so, please describe _____

_____

_____

- OVER PLEASE -

MEDICAL HEALTH

1. Have you been under the care of a medical doctor during the past 2 years? ..... Yes No
2. Have you been hospitalized or had surgery in the past 5 years? ..... Yes No
   If so, please list date and why _____
3. Are you taking any medications, or supplements? (including anything over-the-counter)..... Yes No
   If so, please list: _____
   _____
   _____
   _____
4. Are you allergic to anything? (medications, materials, or food) ..... Yes No
   If so, please list: _____
   _____
5. Have you ever taken any medication for Osteoporosis? Ex. Bisphosphonate drugs, Fosamax, Prolia, Boniva ..... Yes No
6. Do you have any artificial joints? ..... Yes No
   If so, please list joint and date of surgery: _____
7. Does your Physician require you to premedicate with antibiotics before dental treatment? ..... Yes No
   If so, please list antibiotic and dosage: _____
8. Have you lost or gained more than 10 pounds in the past year?..... Yes No
9. Indicate which of the following pertain to you:

Heart (Surgery, Disease, Attack).....	Yes	No	Ulcers.....	Yes	No	Hepatitis A (infectious), B (serum).....	Yes	No
Chest Pain.....	Yes	No	Diabetes.....	Yes	No	Venereal Disease.....	Yes	No
Congenital Heart Disease.....	Yes	No	Thyroid Problem.....	Yes	No	A.I.D.S.....	Yes	No
Heart Murmur.....	Yes	No	Glaucoma.....	Yes	No	H.I.V. Positive.....	Yes	No
High Blood Pressure.....	Yes	No	Contact Lenses.....	Yes	No	Cold Sores/Fever Blisters.....	Yes	No
Mitral Valve Prolapse.....	Yes	No	Emphysema.....	Yes	No	Blood Transfusion.....	Yes	No
Artifical Heart Valve.....	Yes	No	Chronic Cough.....	Yes	No	Hemophilia.....	Yes	No
Heart Pacemaker.....	Yes	No	Tuberculosis.....	Yes	No	Sickle Cell Disease.....	Yes	No
Rheumatic Fever.....	Yes	No	Asthma.....	Yes	No	Bruise Easily.....	Yes	No
Arthritis/Pheumatism.....	Yes	No	Hay Fever.....	Yes	No	Liver Disease.....	Yes	No
Swollen Ankles.....	Yes	No	Latex Sensitivity.....	Yes	No	Yellow Jaundice.....	Yes	No
Stroke.....	Yes	No	Allergies or Hives.....	Yes	No	Neurological Disorders.....	Yes	No
Diet (Special/Pestricted).....	Yes	No	Sinus Trouble.....	Yes	No	Epilepsy or Seizures.....	Yes	No
Artificial Joints (hip, knee, etc.).....	Yes	No	Radiation Therapy.....	Yes	No	Fainting or Dizzy Spells.....	Yes	No
Kidney Trouble.....	Yes	No	Chemotherapy.....	Yes	No	Nervous/Anxious.....	Yes	No
Cancer.....	Yes	No	Tumors.....	Yes	No	Psychiatric/Psychological Care.....	Yes	No

10. Do you have or have you had any disease, condition or problem not listed?..... Yes No
    If so, please list _____
11. **Women:** Are You: **Pregnant?** Yes,____Months No **Nursing?** Yes No **Taking birth control pills?** Yes No

I understand the above information is necessary in order to provide me with dental care in a safe and efficient manner. I understand that withholding information about my medical history can have serious negative consequences to my health and well-being. I have answered all questions to be best of my knowledge. Should further information be needed, you have my permission to ask the appropriate health care provider or agency who may release such information to you. I will notify the doctor of any change in my health or medications.

Patient/Guardian Signature _____ Date _____