ADVANCED DENTAL CARE

Name _____ Date of Birth _____ Sex _____
Home Address _____ Home Phone _____
Business Address _____ Bus. Phone _____
Email _____ Cell Phone _____
Person To Contact In Case of Emergency _____
Marital Status S M W D Soc. Sec. # _____

PATIENT MEDICAL HISTORY UPDATE

Physician _____ Office Phone _____ Date Of Last Physical Examination _____
Physician Address _____

	yes	no
1. Are you under any medical treatment now?	☐	☐
2. Have you had any major operations or any head injuries? yes ☐ no ☐ If so, what? _____		
3. Has a physician ever informed you that you had:	yes	no
AIDS or ARC	☐	☐
Nervous System Disorder (seizures, epilepsy, cerebral palsy)	☐	☐
Rheumatic Fever?	☐	☐
High Blood Pressure or Low Blood Pressure?	☐	☐
Glaucoma?	☐	☐
Any Blood Disease?	☐	☐
Herpes Virus?	☐	☐
Any Kidney Disease/Surgery?	☐	☐
Any Venereal Disease, Sexually Transmitted Disease?	☐	☐
Any Yellow Jaundice, Hepatitis, or Liver Disease?	☐	☐
Prosthetic Devices (artificial devices)?	☐	☐
Gastrointestinal Disorders?	☐	☐
Thyroid Disorders?	☐	☐
Respiratory Disorders (asthma, bronchitis)?	☐	☐
Diabetes?	☐	☐
Coronary Artery Disease (angina, heart attack)?	☐	☐
A Heart Ailment (heart murmur, valvular surgery)?	☐	☐
Arthritis, Rheumatism?	☐	☐
Cancer?	☐	☐
Tuberculosis and/or Positive TB Test	☐	☐
Cerebrovascular Accident (stroke)?	☐	☐
Pneumonia?	☐	☐
Tumors or Growths?	☐	☐
Other?	☐	☐
4. Are you presently taking any medications?	☐	☐

Anesthetics and other medications that may be necessary in your treatment may interact with prescriptions, over-the-counter drugs and medications, and illicit drugs. These interactions could be serious and fatal. You must inform the doctor of all drugs and medications you are now taking or have ever taken. You must also disclose if you are a recovering alcoholic or drug user. All information will be held in strict confidence and will not be disclosed without your prior approval.

5. Do you have any allergies or have you ever had any allergic reactions (medications, hayfever, foods)?	☐	☐
6. Have any wounds healed slowly or presented other complications?	☐	☐
7. Women, are you pregnant? _____ Trimester _____ "Antibiotics decrease effectiveness of birth control pills!"	☐	☐
8. Have you ever had any radiation therapy?	☐	☐
9. Are you on a special diet at this time?	☐	☐

10. Do you smoke? yes ☐ no ☐ If so, how much? _____
11. Describe your general health at this time _____

PATIENT DENTAL HISTORY UPDATE

	yes	no
12. Do you at the present time have any dental complaints?	☐	☐
13. Do you have any pain in or near your ears?	☐	☐
14. Does any part of your mouth hurt when clenched?	☐	☐
15. Have you had any prolonged bleeding following a cut or surgery?	☐	☐
16. Do your gums bleed spontaneously or when you brush your teeth?	☐	☐

17. Is any part of your mouth sore to pressures or irritants (cold, sweets, etc.) yes ☐ no ☐ If so, where? _____
18. If you could wave a magic wand around your mouth and change it any way you want, what changes would you want to make?

_____

19. What do you like best about our office?

_____

20. What do you like least about our office?

_____

21. Would you like us to provide any additional services?

_____

22. Do you have any suggestions to help us serve you better?

_____

Please sign here _____ Today's date _____

Your signature is also a file signature for dental insurance