City Of Lights Dental, P.C. Dr. Lies - Keilty

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MEDICAL & DENTAL HISTORY FORM

Patient Name: _____ _____ ___ _____

Last First MI Preferred Name

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in fairly good health? ○ Yes ○ No

Within the past year, have there been any changes in your general health? ○ Yes ○ No

If yes, please list any medical changes:

_____

_____

_____

Have you ever been instructed by a physician to be premedicated? * ○ Yes ○ No

If yes, please list the medication:

_____

_____

List all medications (including non-prescriptive) that you are currently taking:

_____

_____

_____

_____

_____

_____

_____

_____

What is the date (or approximate date) of your last medical exam?

_____

_____

Your Primary Care Physician's name, address, & phone number:

_____

_____

Please mark any of the following to indicate Yes in response to the question:

- ☐ Have you ever had complications following dental treatment?
- ☐ Are you currently under the care of a physician due to a specific condition?
- ☐ Have you been hospitalized within the last 5 years due to a surgery or illness?
- ☐ Are you taking any blood thinners?
- ☐ Do you use tobacco (smoking or chewing)?

If any of the previous questions are marked, please explain:

_____

_____

_____

Do you have or have you ever had any of the following:

- ☐ Rheumatic heart disease or rheumatic fever
- ☐ Pacemaker
- ☐ Heart defect or heart murmur, heart trouble
- ☐ Stroke
- ☐ Low blood pressure
- ☐ COPD
- ☐ Cough that produces blood
- ☐ Asthma or hay fever
- ☐ Hives or skin rash
- ☐ Diabetes
- ☐ Fainting spells or seizures
- ☐ Cancer chemotherapy
- ☐ Leukemia
- ☐ Anxiety
- ☐ Sexually transmitted disease
- ☐ Joint replacement or implant
- ☐ Acid reflux
- ☐ Kidney trouble
- ☐ Hepatitis, jaundice or liver disease
- ☐ Organ transplant
- ☐ Deafness/Impaired hearing
- ☐ OTHER
- ☐ Scarlet fever
- ☐ Heart surgery
- ☐ Heart attack or chest pain/angina
- ☐ High blood pressure
- ☐ Lung or breathing problems
- ☐ Tuberculosis
- ☐ Persistent cough
- ☐ Sinus trouble
- ☐ Allergies
- ☐ Epilepsy
- ☐ Cancer
- ☐ Radiation treatment
- ☐ Mental health issues
- ☐ Depression
- ☐ AIDS or HIV infection
- ☐ Arthritis or rheumatism
- ☐ Stomach ulcer
- ☐ Thyroid problems
- ☐ High cholesterol
- ☐ Anemia
- ☐ Glaucoma or other eye problems

If any of the previous questions are marked, please explain:

_____

_____

_____

Are you allergic to or have you had reaction to:

- ☐ Local anesthethics like novocaine
- ☐ Penicillin or other antibiotics
- ☐ Sulfa drugs
- ☐ Barbiturates, sedatives, or sleeping pills
- ☐ Aspirin
- ☐ Iodine
- ☐ Latex
- ☐ Codeine or other narcotics
- ☐ Metals
- ☐ OTHER

If any of the previous questions are marked, please explain:

_____

_____

_____

Are you pregnant? (Women Only) ○ Yes ○ No

If Yes, when is the due date? _____

What is the reason for your dental visit today?

_____

_____

When was your last visit to the dentist (ONLY IF to a different office)?

_____

_____

What was done on your last dental visit (ONLY IF to a different office)?

_____

_____

Prior Dentist's name, address, & phone number:

_____

_____

How frequently do you floss your teeth?

○ 1 (+) a day ○ 2 - 6 weekly ○ 1 - 6 monthly ○ Seldom ○ Never

How frequently do you brush your teeth?

○ 3 (+) a day ○ Twice a day ○ Once a day ○ Weekly ○ Seldom

Have you ever had any head, neck or jaw injuries? * ○ Yes ○ No

Have you experienced any of the following problems in your jaw?

☐ Clicking ☐ Pain (joint,ear, side of face) ☐ Difficulty in opening or closing

☐ Difficulty in chewing

Please mark any of the following to indicate Yes in response to the question:

☐ Do your gums bleed when you brush or floss?

☐ Do your teeth experience sensitivity to cold or hot temperatures?

☐ Are any of your teeth currently causing you pain?

☐ Do you grind your teeth (either consciously or during sleep)?

☐ Are any of your teeth loose, or are you concerned about any teeth loosening?

☐ Do you currently have any dental implants, dentures, or partials?

☐ Do you have dry mouth?

☐ Have you ever had braces?

☐ Have you ever had oral surgery?

☐ Have you ever had gum treatment?

☐ Are you interested in straightening your teeth?

☐ Are you interested in bleaching your teeth?

If any of the previous questions are marked, please explain:

_____

_____

_____

If you could change anything about your mouth, teeth, or smile, what would it be?

_____

_____

_____

☐ **To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.**

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian:

Signature _____ **Date** _____

Relationship to Patient:

_____

_____

_____

Response Date: _____