Medical / Dental History Record

WELCOME!

Patient First Name _____ Middle Initial: ____ Last Name: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Email: _____

Date of Birth: _____ Home Phone: _____ Primary Cell Phone: _____

Gender: M / F Marital Status: Single Married Partner Widowed

Occupation: _____ Hobbies: _____

Parent / Guardian (if minor):_____

Are you under a physician's care? Yes / No Physician's Name: _____

Health Care System: Aspirus / Marshfield Clinic / St. Claire's / Ascension / Other: _____

Are you currently taking prescription or non-prescription medications: Yes / No If yes, please list below:

_____

_____

_____

_____

Are you allergic to any of the following:

Aspirin:	**Yes / No**	Erythromycin:	**Yes / No**	Metals:	**Yes / No**
Codeine:	**Yes / No**	Jewelry:	**Yes / No**	Penicillin:	**Yes / No**
Dental Anesthetics:	**Yes / No**	Latex:	**Yes / No**	Tetracycline:	**Yes / No**

Other allergies: _____

For women only…

Are you taking birth control pills? **Yes / No** Are you Pregnant? **Yes / No** Are you nursing? **Yes / No**

Have you ever been or are you now being treated for the following conditions?

✓ Check Box	YES	NO		YES	NO		YES	NO		YES	NO		YES	NO
Anemia, Bruise Easily			Cancer and/or Chemotherapy			Fever Blisters / Cold Sores			HIV / AIDS			Seizures		
Alcohol or Drug Addiction			Colitis			Frequent Headaches			Kidney Problems			Shingles		
Allergies, Sinus Issues			Heart Defect or Heart Murmur			Glaucoma			Liver Disease			Sickle Cell Disease		
Angina			Diabetes			Heart Attack Year:			Mitral Valve Prolapse			Stroke Year:		
Arthritis			Difficulty Breathing			Heart Surgery Year:			Pacemaker Year:			Thyroid Disorder		
Artificial Joint Replacement			Drug Abuse			Hemophilia or Anemia			Pneumonia			Tuberculosis		
Artificial Heart Valve			Emphysema or Frequent Cough			Hepatitis A			Psychiatric Care or Clinical Anxiety			Ulcers		
Asthma			Epilepsy			Hepatitis B or C			Radiation Therapy			Venereal Disease		
Blood Transfusion			Fainting Spells			High Blood Pressure			Scarlet or Rheumatic Fever			Yellow Jaundice		

Please turn over…..

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Do you have any other condition or concern not listed previously? (i.e Steroid Therapy, Parkinson's)
Yes / No If yes, please list below:

_____

Have you ever had to take an antibiotic premedication prior to dental treatment?
Yes / No If yes, due to: ___ a joint replacement ___ a heart defect Other: _____
Do you know the name of the medication you typically take? **Yes / No** Name: _____

Have you taken or are you currently taking a bisphosphonate for osteoporosis or bone density concerns? (i.e. Fosamax, Boniva, Actonel, Atelvia, Reclast, etc.) **Yes / No**

Approximately, when was your last dental visit? _____
Dentist: _____ City or Location: _____
Do you have any concerns at this time? **Yes / No** List here: _____
Do you feel nervous about having dental treatment? **Yes / No**
Have you ever had a bad experience in the dental office? **Yes / No**
Have you ever been told you have periodontal disease? **Yes / No**
Have you ever had periodontal surgery? **Yes / No**

Have you ever or are you now experiencing any of the following:

✓ Check Box	YES	NO		YES	NO		YES	NO		YES	NO
Sensitivity to cold			Popping or clicking of jaw			Teeth whitening			Fingernail biting		
Sensitivity to sweets			Pain around ear or temple			Orthodontic therapy			Cheek biting		
Sensitivity to pressure			Burning tongue			Mouth-breathing only			Smoking or e-cig use		
Bleeding gums			Food impaction			Thumb-sucking			Chewing tobacco		
Foul taste or smell			Complications from extractions			Fluoride supplements			Tongue piercing		
Clenching or grinding			Swelling or lumps in mouth			Retained baby teeth			Recreational sports		
Frequent headaches			Fever blisters			Speech difficulties			Injury to mouth or teeth		

Please share how you care for your teeth?
Brush: ____ times per: ____ with a soft / medium / hard / electric brush (circle one)
Floss: ____ times per: ____ with a floss pick / holder / waterpik (circle one)
Fluoride rinse? (i.e.Act, Crest Pro Health) **Yes / No** **Antibacterial rinse?** (i.e. Listerine) **Yes / No**

The information on this page is correct to the best of my knowledge. I hereby authorize the dental office to administer such medications and perform such diagnostic, photographic, and therapeutic procedures as may be necessary for proper dental care. I understand the use of anesthetic agents embodies certain risk. The risks include, but are not limited to, pain, swelling, bruising, and permanent anesthesia. If I have any changes in my health or medications, I will inform the dentist and staff immediately. I understand that this document will be routinely reviewed and updated by the staff at Szmanda Dental and my verbal consent will be entered as an electronic signature into my e-chart. I understand and agree that these electronic signatures are the same as my handwritten signature for the purposed of validity, enforceability and admissibility. I understand that I may withdraw my consent to the use of a verbal review and electronic signature at any time. In order to withdraw consent, I will notify Szmanda Dental Center, SC in writing that I wish to withdraw consent and request that my future documents be provided in paper format.

Patient or Parent /Guardian Signature: _____ Date: _____

Szmanda Dental Center Witness: _____ Date: _____