

Medical / Dental History Record

WELCOME!

Patient First Name _		Mid	dle Initial:	_ Last Nam	e:				
Address:									
State: Zip Cod	de:	Email:							
Date of Birth:	H	Home Phone:	Primary Cell Phone:						
Gender: M / F			Ма	rital Status:	Single	Married	Partner	Widowed	
Occupation:			Hobbies: _						
Parent / Guardian (if i	minor):								
Are you under a ph	ysician's care?	Yes / No Ph	ysician's Nam	ne:					
Health Care System	n: Aspirus / Ma	arshfield Clinic /	St. Claire's /	Ascension	/ Other	·			
Are you currently to	aking prescript	ion or non-pres	cription med	ications:	Yes / N	lo If yes,	please lis	st below:	
Are you allergic to	any of the follo	wing:							
Aspirin:	Yes / No	Erythromycin:			als:		Yes / N	_	
Codeine: Dental Anesthetics:					-	. .	Yes / N	-	
Dental Anesthetics.	I CS / INU	Lalex.	TES / NO	ı eu	acyclific) :	Yes / N	10	
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	Y E S	N O		Y E S	N O		Y E S	N O		Y E S	N O		Y E S	N O
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.....



Medical / Dental History Record

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:		u have any No If yes, p			condition or concern at below:	no	t lis	sted previously?	(i.e S	Stero	oid Therapy, Parkins	son's	;)
Approximately, when was your last dental visit? Dentist: City or Location: Do you have any concerns at this time? 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 been told you have periodontal disease? Yes / No Have you ever been told you have periodontal disease? Yes / No Have you ever or are you now experiencing any of the following: Check Box Box Box Box Box Box Box Bo	Yes /	No If yes,	du	e to	: a joint replacemer	nt .		a heart defect Ot	her:				
Dentist:									teop	oro	osis or bone dens	sity	
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 nad periodontal surgery? Yes / No Have you ever or are you now experiencing any of the following: Check Box S No Fingernal bitting Box S No Fingernal bitting Box S No Fingernal bitting Sensitivity to cold Popping or clicking of jaw Teeth whitening Fingernal bitting Sensitivity to sweets Sensitivity to pressure Burning tongue Mouth-breathing only Smoking or e-cig use Bleeding gums Food impaction Thumb-sucking Checking of Jaw Swelling or lumps in mouth Retained baby teeth Recreational sports 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 Antibodies, 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, to revise and and my verbal consent will be entered as an electronic signature for the same as my handwritten signature of 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.								City or Locati	on.				
Check Box	Do you Do you Have y Have y	u have any u feel nervo you ever ha you ever be you ever ha	cor ous od a een od p	abo bao told erio	ns at this time? Yes / I ut having dental treatmed experience in the dental you have periodontal dontal surgery? Yes /	No ent tal lise No	List c? Y office ease o	st here: /es / No ce? Yes / No e? 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 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) 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 the dentits 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 ve-chart. 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:	паче				ou now experiencing a	any		the following.	.,				
Sensitivity to sweets	✓		Е			Y E S			Ε			Е	
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:	Sensitivity	to cold			Popping or clicking of jaw			Teeth whitening			Fingernail biting		
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:	Sensitivity	to sweets			Pain around ear or temple			Orthodontic therapy			Cheek biting		
Foul taste or smell Complications from extractions Fluoride supplements Tongue piercing Recreational sports 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:	Sensitivity	to pressure			Burning tongue			Mouth-breathing only			Smoking or e-cig use		
Clenching or grinding	Bleeding g	jums			Food impaction			Thumb-sucking			Chewing tobacco		
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:	Foul taste	or smell			Complications from extractions			Fluoride supplements			Tongue piercing		
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:	Clenching	or grinding			Swelling or lumps in mouth			Retained baby teeth			Recreational sports		
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:	Frequent h	neadaches			Fever blisters			Speech difficulties			Injury to mouth or teeth		
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Szmanda Dental Center Witness: Date:	any time. be provid	In order to withd ed in paper format	raw d at. /Gu	onsei iard	nt, I will notify Szmanda Dental Cer	nter,	SC ir	n writing that I wish to withdr	aw cor	nsent	and request that my future Date:	docum	nents