RIGHT SMILE CENTER

PATIENT MEDICAL HISTORY

PATIENT'S NAME: ____ DATE___________

In our office you are the reason we are here. We would like to give you dental care designed to your individual needs and ask that you aid us in answering the following questions as completely as possible. Your records are held in strict confidence, and will not be released to anyone without your written consent.

Do you require premedication with antibiotics before dental treatments? Y N

For what condition? ____

DENTAL HISTORY

Reason for initial visit ____

Date of last dental visit _____________ Last cleaning _____________ Last x-rays ________________

Former dentist _______________________________________ Phone number ___________________

Is there anything that concerns you about your mouth/gums/teeth/smile?____________________________

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How often do you brush/day__________________ floss_______________

Do you have any of the following oral health issues:

Bad Breath	Y	Wisdom teeth removed	Y
Clicking /popping of jaw	Y	Periodontal treatment / Gum treatment	Y
Bleeding / sore gums	Y	Blisters / canker sores	Y
Sensitivity to hot / cold	Y	Sensitivity when biting	Y
Loose teeth	Y	Orthodontic treatment	Y
Sensitivity to sweets	Y	Discolorations in mouth	Y
Dry mouth	Y	Grinding / Clenching of teeth	Y
Jaw surgery / Tooth removal	Y	Dental implants	Y

MEDICAL HISTORY

Name of family physician:_____________________________________Phone #_______________________

Date of last visit with physician:__________________________

DRUG ALLERGIES

Codiene	Y	Nitrous oxide (laughing gas)	Y
Barbituates	Y	Penicillin	Y
Dental anesthetic (novacaine, etc)	Y	Sulfa drugs	Y
Latex	Y	Aspirin	Y
Erythromycin	Y	Others	

-SEE OTHER SIDE TO COMPLETE FORM-

MEDICATIONS

Please list any prescription or nonprescription medication you currently take (or are supposed to be taking), dosage, and for what condition:

Medication	Dosage	Medication	Dosage
________________	________________________	____________________	___________________
________________	________________________	____________________	___________________

Have you taken Cortisone or any other steroids in the past 12 months? ____________________________________

Recreational drugs can also interfere with your dental health and anesthetics we may use during your treatment. Please inform us before treatment if any have been used with a week of your appointments. Any information is held as a part of the Doctor/Patient confidentiality relationship.

Do you have or have you had any of the following;

Heart Disease / failure /attack................. Y
Angina pectoris / chest pains.................. Y
Pace maker / defibrillator....................... Y
High / low blood pressure...................... Y
Rheumatic fever.................................... Y
Congenital heart defect / murmur........... Y
Artificial heart valve (Year replaced _______) Y
Mitral valve prolapse / heart murmur...... Y
Stroke / aneurysm.................................. Y
Blood transfusion (Year_________)..... Y
Anemia / Sickle Cell disease................ Y
Abnormal bleeding or healing.............. Y
Fainting / dizzy spells.......................... Y
Severe headaches................................ Y
Epilepsy / seizures / convulsions......... Y
HIV positive / AIDS........................... Y
Possible exposure to communicable diseases.. Y
Venereal Disease / STD...................... Y
Transplant (Type______________ Year________)
Glaucoma.. Y
Hepatitis (Type_____)....................... Y
Liver disease / cirrhosis / jaundice…... Y

Stomach problems / ulcers.............. Y
Sinus trouble..................................... Y
Breathing difficulties......................... Y
Asthma/ emphysema........................ Y
Tuberculosis.................................... Y
Arthritis... Y
Artificial joint (hip, knee, etc) .... Y
Diabetes (Type_____)...................... Y
Thyroid disease................................ Y
Kidney problems / failure / dialysis... Y
Drug / alcohol addiction.................... Y
Cancer / tumor (Type_______________ Year______)................................... Y
Radiation / x-ray treatment............... Y
Chemotherapy................................. Y
Autoimmune disorder (MS, Lupus, etc.)... Y
Frequent nose bleeds....................... Y
Do you use tobacco/E products? (Type______________).................... Y
WOMEN: Are you pregnant or nursing...................................... Y
Birth control pills .... Y

Have you had any operations, surgery or been hospitalized? ____
Do you have any conditions not listed above? ____

The information on this patient medical form is accurate and complete to the best of my knowledge and is only for use in my treatment, billing, and or processing of insurance benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. Should there be any change in my medical condition prior to my next treatment, I promise to apprise my dentist in writing of the changes in my medical condition.

PATIENT'S SIGNATURE____DATE___________

Medical updates: Date_______ Date_______ Date_______ Date_______ Date_______