

Patient Information and Medical-Dental History (Stephen Family Dentistry, P.C)

Patient's Name _____ DOB _____ SSN _____
First MI Last

male female single married minor

Name of Spouse or if Child, Name of parent(s) _____

First Last First Last

Mailing address: _____ City/Town _____

State, Zip _____ Phone(H) _____ (W) _____

Patient/Parent employed by(address) _____

Who is responsible for payment not covered by insurance? _____

Medical History

yes	no	yes	no	yes	no			
<input type="checkbox"/>	<input type="checkbox"/>	Allergies to anesthetics	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	<input type="checkbox"/>	Any heart problem	<input type="checkbox"/>	<input type="checkbox"/>	Heart problem	<input type="checkbox"/>	<input type="checkbox"/>	Eye Disorders
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problem	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis
<input type="checkbox"/>	<input type="checkbox"/>	Neurological problems	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Radiation treatments	<input type="checkbox"/>	<input type="checkbox"/>	Kidney problems	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer or Colitis
<input type="checkbox"/>	<input type="checkbox"/>	Excessive bleeding from cut	<input type="checkbox"/>	<input type="checkbox"/>	Liver problems	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy; If yes, Due _____
<input type="checkbox"/>	<input type="checkbox"/>	Anemia or blood problem	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Asthma or breathing problem
<input type="checkbox"/>	<input type="checkbox"/>	Joint replacement / implant	<input type="checkbox"/>	<input type="checkbox"/>	Any major operation	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever or allergies in general
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric care, depression	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease
<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>	Other _____
<input type="checkbox"/>	<input type="checkbox"/>	MVP, MIT	<input type="checkbox"/>	<input type="checkbox"/>	Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	Allergy to: ___ Penicillin, ___ Motrin, ___ Sulfa
<input type="checkbox"/>	<input type="checkbox"/>	Pace make	<input type="checkbox"/>	<input type="checkbox"/>	AIDS, HIV, Herpes	<input type="checkbox"/>	<input type="checkbox"/>	To other Med: _____
<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A B C	<input type="checkbox"/>	<input type="checkbox"/>	Other Med problem: _____

Your physician's Name _____ Phone _____

Date of last visit to your doctor _____ Purpose of visit _____

Have you ever, or do you now take illegal drugs _____ If yes, what _____

Are you taking any medication _____ If yes, what _____

Dental History

yes	no	yes	no	yes	no			
<input type="checkbox"/>	<input type="checkbox"/>	Teeth sensitive to cold, hot, etc	<input type="checkbox"/>	<input type="checkbox"/>	Unusual sounds in jaw joint	<input type="checkbox"/>	<input type="checkbox"/>	Oral habits, i.e. sucking finger
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding gums when brushing	<input type="checkbox"/>	<input type="checkbox"/>	Oral cancer, tumor	<input type="checkbox"/>	<input type="checkbox"/>	Smoking, long _____
<input type="checkbox"/>	<input type="checkbox"/>	Food impaction	<input type="checkbox"/>	<input type="checkbox"/>	Bad breath	<input type="checkbox"/>	<input type="checkbox"/>	type, quantity _____
<input type="checkbox"/>	<input type="checkbox"/>	Clenching or grinding teeth	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to dental anesthesia	<input type="checkbox"/>	<input type="checkbox"/>	Using dental floss
<input type="checkbox"/>	<input type="checkbox"/>	Burning of tongue, mucosa	<input type="checkbox"/>	<input type="checkbox"/>	Complications from extraction	<input type="checkbox"/>	<input type="checkbox"/>	Using inter dental stimulators
<input type="checkbox"/>	<input type="checkbox"/>	Swelling of lumps in mouth	<input type="checkbox"/>	<input type="checkbox"/>	Periodontal treatment	<input type="checkbox"/>	<input type="checkbox"/>	Using mouth rising
<input type="checkbox"/>	<input type="checkbox"/>	Pain around ear	<input type="checkbox"/>	<input type="checkbox"/>	Orthodontic treatment	<input type="checkbox"/>	<input type="checkbox"/>	Fluoride supplements

Date of last visit of your dentist _____ Where _____

Note: A change in your health status should be reported to the office at the earliest possible time.

To the best of my knowledge, the foregoing questions have been accurately answered;

I grant the right to the dentist to release health information obtained from me, and information about my dental treatment to third party payers, and/or other health practitioners

Person completing the form: Signature _____ Print Name _____

If other than patient, indicate relationship _____ Date _____