MORGAN
FAMILY DENTAL

Patient Dental & Medical Health History Information

To our patients: Please understand that we may ask follow-up questions to make sure we have all of the information we need. Our goal is to provide you with the highest quality of care possible. Please print or write legibly.

PATIENT INFORMATION • SIDE • A

PATIENT INFORMATION

Last Name: **First Name:** **Middle Initial:**

Main Phone: **Cell Phone:** **Work Phone:**

Mailing Address: **City:** **State:** **Zip:**

Email Address: **DOB:** / / **Soc Sec #:**

Gender: M ☐ F ☐ Prefer not to answer ☐ **Preferred method of communication:** Phone ☐ Text ☐ Email ☐

Marital Status: M ☐ S ☐ D ☐ W ☐ **Spouses Name:** **Phone:**

Occupation:

Who may we thank for referring you to us? **Did you find us on your own?** Y ☐ N ☐

Emergency Contact Name: **Relationship:** **Phone:**

If you are completing this form for another person, what is your name and relationship to that person?

Name: _____ **Relationship:** _____

DENTAL HISTORY & SYMPTOMS

What is the reason for your visit today? _____

_____

_____

Are you currently experiencing any dental pain or discomfort? Y ☐ N ☐ **If yes, where?**

When was your last dental exam? / / **What was done?**

When was the last time you had dental X-rays taken? / /

Please mark an "X" in the box ONLY if this applies to you.

Is it hard to open your mouth? ☐

Does it hurt to chew, bite or swallow? ☐

Do your gums bleed when you brush or floss your teeth? ☐

Have you ever had periodontal (gum) treatments (scaling / root planing)? ☐

If yes, when and at which dental office? _____

_____

Do you have or have you ever had any sores or growths in your mouth? ☐

Do you clench or grind your teeth? ☐

Does your jaw click, pop or hurt? ☐

Do you have earaches or neck pain? ☐

Does dental treatment make you nervous? ☐

Have you ever experienced any of these sleep-related breathing disorders? ☐

☐ Mouth breathing ☐ Snoring ☐ Trouble breathing during sleep

Have you ever had a serious injury to your head or mouth? ☐

If yes, please describe what happened and when: _____

_____

Have you ever had problems with dental treatment in the past? ☐

If yes, please describe: _____

_____

Have you ever had a reaction to, or problem with, dental anesthetics / anesthesia? ☐

If yes, please describe: _____

_____

Are you unhappy with your smile? ☐

If yes, why? Please mark all that apply:

☐ The color of my teeth ☐ The shape of my teeth ☐ The position of my teeth

☐ Other (Please describe): _____

_____

HIPAA RELEASE INFO

Can we discuss your dental care with another individual? Y ☐ N ☐ **If yes, please list name(s) below.**

_____

_____

MEDICATIONS & OTHER PRODUCTS / SUBSTANCES

Please use an "X" to mark your answers to the following questions. Yes No

Are you taking any **blood thinners** (i.e., Coumadin, Warfarin, rivaroxaban (Xarelto®), dabigatran (Pradaxa®), clopidogrel (Plavix®), heparin or aspirin)? ☐ ☐

Are you taking any medication to treat **osteoporosis**? ☐ ☐

Do you take any other **prescriptions and/or over-the-counter medicine(s), vitamins, herbs and/or supplements**? ☐ ☐

If yes, please list them here. _____

_____

_____

Do you use any form of **tobacco or nicotine products** (cigarettes, cigars, chewing tobacco)? ☐ ☐

Do you use **vaping products**? ☐ ☐

Do you consume **alcoholic beverages**? ☐ **Yes** ☐ **No** **If yes, how often is your use?** ☐ **Daily** ☐ **Weekly** ☐ **Monthly** ☐ **Annually**

Do you use **controlled substances** (drugs), including marijuana, for either medicinal or recreational reasons? ☐ ☐

If yes, what substances? _____ **If yes, how often is your use?** ☐ **Daily** ☐ **Several times per week** ☐ **Weekly** ☐ **Occasionally**

Was the substance prescribed by a doctor? ☐ **Yes** ☐ **No** **If yes, for what reason(s)?** _____

CURRENT & PAST MEDICAL CONDITIONS

Are you currently under the care of a physician? ☐ **Yes** ☐ **No** **If yes, for which condition(s)?** _____

_____

Date of last physical exam: / /	**What is your normal blood pressure (systolic / diastolic)?**
Physician's or Clinic Name:	**Phone:**

Please use an "X" to mark your answers to the following questions. Yes No

Are you currently in good physical health? ☐ ☐

Are you currently being treated by a physician? ☐ ☐

Has a physician recommended that you take **antibiotics** before having dental treatment? ☐ ☐

If yes, which one(s)? _____

Have you had any type of **joint replacement**, either total or partial surgery (such as for a hip, knee, shoulder, etc.)? ☐ ☐

Have you had a **heart valve replacement or heart surgery**? ☐ ☐

Have you ever been diagnosed with **oral cancer**? ☐ ☐

Has a family member ever been diagnosed with **oral cancer**? ☐ ☐

If yes, who? _____

Have you had a **serious illness, operation or been hospitalized** in the past 5 years? ☐ ☐

Do you need an **EpiPen®** for any allergy? ☐ ☐

HEALTH CONDITIONS

Please use an "X" to mark your answers to the following questions.

Do you have, or have you been diagnosed with, any of the following conditions?

	Yes	No		Yes	No		Yes	No
ADD/ADHD	☐	☐	Dry Mouth	☐	☐	Low Blood Pressure	☐	☐
Allergies	☐	☐	Epilepsy	☐	☐	Mental Health	☐	☐
Angina	☐	☐	Fainting Spells	☐	☐	Migraines	☐	☐
Anxiety	☐	☐	Frequent Headaches	☐	☐	Mitral Valve	☐	☐
Arthritis	☐	☐	GE Reflux	☐	☐	Pacemaker	☐	☐
Artificial Bones	☐	☐	HIV/AIDS	☐	☐	Pain in Jaw Joints	☐	☐
Artificial Heart	☐	☐	Heart Attack	☐	☐	Radiation Therapy	☐	☐
Asthma	☐	☐	Heart Disease	☐	☐	Rheumatic Fever	☐	☐
Cancer	☐	☐	Heart Surgery	☐	☐	Seizures	☐	☐
Colitis	☐	☐	Hepatitis B	☐	☐	Sinus Problems	☐	☐
Congenital Heart	☐	☐	High Blood Pressure	☐	☐	Stroke	☐	☐
Depression	☐	☐	High Cholesterol	☐	☐	Thyroid Problems	☐	☐
Diabetes	☐	☐	Joint Replacement	☐	☐	Tuberculosis	☐	☐
Difficulty Breathing	☐	☐	Kidney Problems	☐	☐	Ulcers	☐	☐

FOR WOMAN

Please use an "X" to mark your answers.

Pregnant? Y ☐ N ☐

Nursing? Y ☐ N ☐

Birth Control? Y ☐ N ☐

ALLERGIES

Please use an "X" to mark all that apply.

☐ Aspirin ☐ Erythromycin ☐ Metal ☐ Tetracycline

☐ Codeine ☐ Jewelry ☐ Milk ☐ **Other** _____

☐ Dental Anesthetics ☐ Latex ☐ Penicillin _____

FINANCIAL CONSENT

I agree to pay for services that are not covered, or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.

SIGNATURE: X _____ **DATE:** _____

MEDICAL INFORMATION • SIDE • B