MEDICAL ALERT:

MEDICAL – DENTAL HISTORY

Name_____ Home Phone_____
Address_____ Cell Phone_____
City_____ State, Zip_____ Work Phone_____
Date of Birth_____ Age___
In case of Emergency notify_____ Relationship_____ Phone_____

MEDICAL:

Date of Last Physical Exam_____
Physician's Name_____ Address_____ Phone_____
If you have multiple physicians, please list with specialty_____
Please list any current health problems_____
Have you been hospitalized or had any surgeries in the last 5 years? ___Yes ___No
*If so, please explain*_____
Please list ANY medications you are taking including the dosage:
Prescription_____
_____
Over-the-Counter / Herbal Supplements_____
For women only:
Are you pregnant or trying to become pregnant? ___Yes ___No *Number of weeks*_____
Are you nursing? ___Yes ___No
Are you taking birth control pills? ___Yes ___No
Do you smoke or chew tobacco? ___Yes ___No
Were you ever told you needed to take antibiotics (premedicate) before dental treatment? ___Yes ___No
Please circle any of the following which you <u>have had</u> or <u>presently have</u>:

Alcoholism or drug addiction
Autoimmune disease:
- Lupus erythematosus
- Rheumatoid arthritis
- Sjogren's syndrome

Bisphosphonate therapy
- Specify: *Oral* or *IV*

Blood disorder:
- Abnormal bleeding
- Anemia
- Blood transfusion
- Hemophilia
- Leukemia
- Sickle cell anemia

Cancer/ Chemo/ Radiation
Cardiovascular disease:
- Angina
- Arteriosclerosis
- Artificial heart valves
- Congenital heart disease
- Coronary insufficiency
- Coronary occlusion
- Damaged heart valves
- Heart attack
- Heart murmur
- High blood pressure
- High cholesterol
- Low blood pressure
- Mitral valve prolapse
- Pacemaker
- Rheumatic heart disease
- Stroke

Chest pain upon exertion
Chronic pain
Endocrine disorder:
- Diabetes, Type I
- Diabetes, Type II
- Thyroid problems

Epilepsy or seizures
Excessive thirst
Excessive urination
Gastrointestinal problem:
- Acid reflux
- Ulcers

Glaucoma
Infectious disease:
- AIDS or HIV
- Chronic cough
- Hepatitis A
- Hepatitis B or C
- Tuberculosis

Kidney disease
Migraines
Persistent swollen glands
Psychiatric disorder:
- Anxiety
- Bipolar disorder
- Dementia/Memory Loss
- Depression
- Eating disorder
  - Specify:_____
- O.C.D.
- Schizophrenia

Respiratory problem:
- Asthma
- COPD
- Emphysema

Severe or rapid weight loss
Sinus trouble
Skeletal disorder:
- Joint replacement
  - Type: *hip knee elbow*
  - Date_____
- Osteoporosis / Osteopenia

Sleep apnea
Steroid therapy
Other_____
None of the above

Please circle any of the following to which you have had an Allergic Reaction:

Aspirin	*Dental Anesthetics*	*Jewelry*	*Metals*	*Sulfa Drugs*	*Other*_____
Codeine	*Erythromycin*	*Latex*	*Penicillin*	*Tetracycline*	*None*

Reserved for Doctor's review of medical history_____
_____
_____
_____

DENTAL:

Are you having a dental problem now? ___Yes ___No *Explain*_____
When was your last dental exam? _____ Previous Dentist:_____
Have you ever had a full mouth series of x-rays (18-20 films)? ___Yes ___No *Date*_____
Have you ever had a panoramic x-ray? ___Yes ___No *Date*_____
Do you wear full or partial dentures? ___Yes ___No
Have you ever had your wisdom teeth extracted? ___Yes ___No
Have you ever had orthodontic treatment? ___Yes ___No
Have you ever had periodontal (gum) treatment? ___Yes ___No
How often do you brush?_____ What type of toothbrush do you use? _____
How often do you floss?_____ Do you use any other interdental aids? _____
Do you use any mouth rinses? ___Yes ___No *Type*_____
Please circle if you drink any of the following: *Coffee* *Tea* *Iced tea* *Soda* *Sports Drinks*
Amount_____
Do you prefer local anesthetic for dental work (Novocaine)? ___Yes ___No
Are you happy with the way your teeth look? ___Yes ___No
Please list anything you would like to change or discuss about your teeth with the Dentist_____

Please circle if you have any of the following problems:

Abscesses	Difficulty chewing	Pain in jaw joint
Bad breath	Dry mouth	Sensitive gums
Bites nails or objects	Food traps	Sensitive teeth:
Bleeding gums	Frequent headaches	*Hot*
Chewing on only one side	Gags easily	*Cold*
Clenching/ grinding	Loose teeth	*Sweet*
Cold sores	Missing teeth	Sores or ulcers
Dental fear	Noise in jaw joint	Stained teeth

Reserved for Doctor's review of dental history_____

CONSENT

The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that my dental insurance is a contract between me and the insurance carrier, and not between the insurance carrier and McCracken Family Dentistry and that I am still fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior financial arrangements have been made. I also assign all insurance benefits to McCracken Family Dentistry. Any payments received by McCracken Family Dentistry from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a late charge will be added to any overdue balance exceeding thirty days. (1.5% per month)

PATIENT Signature (Parent of Child)_____ Date_____

DENTIST Signature _____ Date_____