

DENTAL/MEDICAL HISTORY FORM

The Dental/Medical History Form should be answered completely and as accurately as possible. This will allow us to provide appropriate care.

Last Name: _____ First name: _____ Middle Initial: _____ Male Female Other

Street Address: _____ City _____ State _____ Zip: _____

Date of Birth: _____ mm/dd/yr How do you prefer we contact you? Phone Call Text Email

Cell Phone: _____ Email: _____

(Optional): Occupation: _____ Previous Dentist/Clinic: _____

Emergency contact: _____ Phone: _____

DENTAL HISTORY

PLEASE CHECK IF YES AND EXPLAIN		✓			✓
1	Do your gums bleed when you brush or floss?		2	Do you experience frequent ulcers in your mouth?	
3	Are your teeth sensitive to hot, cold, sweets, or pressure?		4	Do you currently have any sores or ulcers in your mouth?	
5	Does food or floss catch between your teeth?		6	Do you participate in energetic sports or activities?	
7	Is your mouth often dry?		8	Do you grind your teeth?	
9	Have you had periodontal (gum) treatment?		10	Do you wear dentures or partial dentures?	
11	Have you had orthodontic treatment (braces)?		12	Have you had any serious injury to your head or mouth?	
13	Do you have clicking, Popping, or other discomfort in your jaw?		14	Have you had any problems related to dental treatment?	
15	Are you currently experiencing dental pain or discomfort?	<input type="checkbox"/> YES <input type="checkbox"/> NO			
16	Date of your last dental Exam and X-rays?	mm/dd/yr			
17	Date of your last dental cleaning?	mm/dd/yr			
18	Other comments:				

What is the reason for your visit today?

MEDICAL HISTORY

PLEASE CHECK IF YES AND EXPLAIN		✓			✓
1	Are you under a physician's care now?		2	Ever been hospitalized or had a major operation?	
3	Have you ever taken Fosamax, Boniva, Actonel, Reclast or any other bisphosphonates?		4	Do you take, or have you taken Warfarin, Eliquis, Xarelto, or any other anticoagulants?	

CONDITIONS If Yes Please Explain	✓		✓		✓
Anemia		Heart (Surgery, Disease, Attack)		Leukemia	
Arthritis/rheumatism		Heart murmur		Liver disease	
Artificial joints		Hemophilia		Lung disease	
Cancer		Hepatitis		Osteoporosis	
Congenital heart disease		Herpes		Renal dialysis	
Cough, tuberculosis, asthma		HIV/AIDS		Sickle cell disease	
Diabetes		High/low blood pressure		Stroke	
Epilepsy or seizures		High/low blood sugar		Thyroid problems	
Fainting or dizziness		Kidney problems		Ulcers	
Allergies to medications, nitrile, etc	<input type="checkbox"/> YES <input type="checkbox"/> NO				
Pregnant/nursing	<input type="checkbox"/> YES <input type="checkbox"/> NO				
Any other unlisted conditions:					

Medication List/Comments:

I understand the importance of complete and truthful medical and dental information and that incorrect information could pose a serious threat to my health. To the best of my knowledge the answers to the preceding questions are true and correct. I will not hold Eldridge Family Dental or any person who provides dental services responsible for any actions that they take or do not take because of any errors or omissions that I may have made in the completion of this form. I consent to the release of medical/dental information to my dentist, physician, or other healthcare professional if requested. Further, if I ever have any change in my health, or if my medications change, I will inform my dentist at my next appointment. I hereby grant permission to be treated by staff of Eldridge Family Dental.

Signature of Patient or Patient's Representative

Date

Print Patient Name

Relationship to Patient (If not signed by the Patient)