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	
☐	☐	Allergies to anesthetics	☐	☐	Stroke	☐	☐	Cancer
☐	☐	Any heart problem	☐	☐	Heart problem	☐	☐	Eye Disorders
☐	☐	High blood pressure	☐	☐	Thyroid problem	☐	☐	Tonsillitis
☐	☐	Neurological problems	☐	☐	Diabetes	☐	☐	Tuberculosis
☐	☐	Radiation treatments	☐	☐	Kidney problems	☐	☐	Ulcer or Colitis
☐	☐	Excessive bleeding from cut	☐	☐	Liver problems	☐	☐	Pregnancy; If yes, Due_____
☐	☐	Anemia or blood problem	☐	☐	Emphysema	☐	☐	Asthma or breathing problem
☐	☐	Joint replacement / implant	☐	☐	Any major operation	☐	☐	Hay fever or allergies in general
☐	☐	Arthritis	☐	☐	Psychiatric care, depression	☐	☐	Venereal Disease
☐	☐	Heart murmur	☐	☐	Rheumatic fever	☐	☐	Other_____
☐	☐	MVP, MIT	☐	☐	Sinus problems	☐	☐	Allergy to: ___Penicillin, ___Motrin, ___Sulfa
☐	☐	Pace make	☐	☐	AIDS, HIV, Herpes			To other Med: _____
☐	☐	Angina	☐	☐	Hepatitis A B C	☐	☐	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	
☐	☐	Teeth sensitive to cold, hot, etc	☐	☐	Unusual sounds in jaw joint	☐	☐	Oral habits, i.e. sucking finger
☐	☐	Bleeding gums when brushing	☐	☐	Oral cancer, tumor	☐	☐	Smoking, long_____
☐	☐	Food impaction	☐	☐	Bad breath			type, quantity_____
☐	☐	Clenching or grinding teeth	☐	☐	Allergies to dental anesthesia	☐	☐	Using dental floss
☐	☐	Burning of tongue, mucosa	☐	☐	Complications from extraction	☐	☐	Using inter dental stimulators
☐	☐	Swelling of lumps in mouth	☐	☐	Periodontal treatment	☐	☐	Using mouth rising
☐	☐	Pain around ear	☐	☐	Orthodontic treatment	☐	☐	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_____

(turn over)