Medical and Dental History- Innovation Drive Dental

innovation drive dental
family & cosmetic dentistry

Please take a moment to let us know about your medical and dental history so we may serve you more effectively.

Patient Name:

Please check any of the following that may apply to you:

- ☐ Sensitive teeth (hot/cold/sweets)
- ☐ Tooth pain or discomfort when chewing
- ☐ Jaw joint pain
- ☐ Broken teeth or fillings
- ☐ Grinding or clenching of teeth
- ☐ Bleeding, swollen or irritated gums
- ☐ Loose, tipped or shifting teeth
- ☐ Bad breath or bad taste in mouth
- ☐ Dentures/Partial Dentures
- ☐ Smoke or use Chewing Tobacco
  - How much?
  - How many years?

Do you floss?
☐ Yes ☐ No

How often do you brush per day?
☐ 1 ☐ 2 ☐ 3

- ☐ AIDS/HIV
- ☐ Allergies (seasonal)
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Bronchitis
- ☐ Bruise easily
- ☐ Cancer
- ☐ Chemo/Radiation
- ☐ Diabetes
- ☐ Respiratory problem

- ☐ Drug/alcohol addiction
- ☐ Eating Disorder
- ☐ Fainting
- ☐ Heart Condition
- ☐ Heart Murmur
- ☐ Artificial Heart Valve
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Kidney/Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pregnant
- ☐ Contraceptive Use

- ☐ Seizures
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ High Cholesterol
- ☐ Pacemaker
- ☐ Penicillin Allergy
- ☐ Latex Allergy
- ☐ Depression
- ☐ Anxiety
- ☐ Dizziness
- ☐ Ulcers
- ☐ Rheumatic Fever
- ☐ Any other health issues?

Are you currently under the care of a physician? ☐ Yes ☐ No
If so, for what condition?

Family Physician Information:

Name: **Phone Number:**

Are you currently taking any prescription medications: ☐ Yes ☐ No
If so, please list:
Do you have any allergies to any medications NOT listed above?
Have you ever had complications following medical treatment? ☐ Yes ☐ No **Dental Treatment?** ☐ Yes ☐ No

On a scale of 1-10 (1=Not Important; 10=Very Important), how important is your dental health?

When was your last dental visit?
When was your last oral cancer screening?
When was your last set of complete x-rays? (approx. 16 x-rays)
What is the most important thing to you about your dental visit today?
Do you grind your teeth (either consciously or during sleep) ☐ Yes ☐ No
If you could whiten your teeth for a cost that anyone can afford, would you do it? ☐ Yes ☐ No
If you could change anything about your mouth, teeth or smile, what would it be?

I hereby certify that I have read and understand the previous information and that it is accurate and tru to the best o fmy knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I understand that I am financially responsible for services rendered to me or to my dependents that are not fully covered by my insurance (if applicable) and I may be billed for this remaining balance. I agree to pay all uninsured services or insurance differences at the time services are performed, unless other arrangements are made.

Patient's (guardian's) Signature: **Date:**