Medical History

About You

Today's Date:_____

Name: _____ Preferred name: _____ Birth date: _____ Age: _____ ☐Female ☐Male

Street address: _____ City, State, Zip: _____

Mobile #: (_____)_____ Home #: (_____)_____ Work #: (_____)_____

SS#: _____ Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Preferred way to receive reminder of upcoming appointments: ☐ Mobile ☐ Home ☐ Work ☐ Text ☐ Email

Best time to reach you: _____ ☐ AM ☐ PM Is it okay to leave private messages on voicemail? Y N

Email address: _____ (appointment reminders only)

Why have you come to the dentist today? _____ Are you currently in pain? Y N

Employed: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Not Employed ☐ Student School name: _____

Employer: _____ Address: _____

Emergency contact: _____ Phone#: _____ Relation: _____

Physician's name: _____ Phone #: _____City:_____ Date of last visit: _____

Pharmacy name: _____ Location: _____ Phone number: _____

Medications:

Please list any and ALL Medications you are taking including prescription, over the counter, herbal, vitamins and minerals, weight loss aids, cold or allergy medicine, pain medicine, etc:

_____

_____

_____

Women:

Are you taking Birth Control Pills?	Yes	No	
…Hormone Replacement?	Yes	No	
Are you Pregnant?	Yes	No	Week #_____
Are you Nursing?	Yes	No	

Allergies:

Y	N	Penicillin	Y	N	Dental Anesthetics (Novocaine)
Y	N	Aspirin	Y	N	Sulfa drugs
Y	N	Tetracycline	Y	N	Latex
Y	N	Codeine	Y	N	Other

Please list any others not mentioned including food allergies: _____

_____

Do you smoke?	Y	N	Pks per day_____ Number of Years_____
Do you use any other tobacco products? (Pipe, cigars, snuff, dip, chew, vaping)	Y	N	Amount Daily_____

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Do you or have you ever had any of the following diseases or conditions?
(**Please circle either Y or N for <u>each</u> condition**)

Y	N	High or Low Blood Pressure	Y	N	Venereal Diseases/ STD's
Y	N	Heart Attack	Y	N	Osteoporosis
Y	N	Rheumatic or Scarlet Fever	Y	N	Arthritis (Osteo)
Y	N	Congenital Heart Defect	Y	N	Arthritis (Rheumatoid)
Y	N	Mitral Valve Prolapse	Y	N	Cancer (Type)_____
Y	N	Pacemaker	Y	N	Chemotherapy
Y	N	Have you been advised to take **ANTIBIOTICS** before dental appts?	Y	N	Radiation Treatment (Date)_____
			Y	N	Glaucoma or Cataracts (eye problems)
Y	N	Heart Surgery	Y	N	Sinus Problems
Y	N	Artificial Heart Valve, replacements	Y	N	Tuberculosis (TB)
Y	N	High Cholesterol	Y	N	Severe/ Frequent Headaches/Migraines
Y	N	Diabetes □ Type I □ Type II	Y	N	Depression
Y	N	Difficulty Breathing, Shortness of Breath	Y	N	Anxiety
Y	N	Emphysema	Y	N	ADHD/ADD
Y	N	Bronchitis	Y	N	Psychiatric Problems
Y	N	Asthma	Y	N	Brain or Neural conditions
Y	N	COPD	Y	N	Artificial Bones/Joints (knee, hip etc)
Y	N	Thyroid Problems	Y	N	OSA/ Sleep Apnea
Y	N	Stroke	Y	N	Snoring
Y	N	Blood Transfusion	Y	N	CPAP Machine
Y	N	Hemophilia/ Abnormal Bleeding	Y	N	Kidney Disease
Y	N	Anemia	Y	N	Gout
Y	N	HIV~AIDS	Y	N	Epilepsy/Seizures/Fainting spells
Y	N	Shingles	Y	N	Ulcers
Y	N	Fever Blisters/ Cold Sores	Y	N	Colitis
Y	N	Drug/ Alcohol Abuse	Y	N	HPV (Human Papilloma Virus)
Y	N	Hepatitis	Y	N	Hospitalized for any reason

Please list any pertinent information and serious medical conditions you have ever had and explain

_____

_____

Dental History:

Your current dental health is □ Good □ Fair □ Poor

Have you ever had serious/difficult problems associated with any previous dental work? Y N

Do you now or have you ever experienced pain/ discomfort in your jaw joint (TMJ/TMD)? Y N

Do you like your smile? Y N

How many times a **week** do you floss? _____ How many times a **day** do you brush? _____

Do your gums ever bleed? Y N

Type of toothbrush bristles? □ Hard □ Medium □ Soft Do you use an electric toothbrush? Y N

I acknowledge that the information given today is accurate to the best of my knowledge. I understand that this information will be held in the strictest confidence as outlined by HIPAA guidelines. I am aware it is my responsibility to inform the office immediately of any and all changes in my medical status. I also understand that every insurance policy is different and that I owe the total amount charged to my account regardless of insurance coverage. Any estimates of insurance coverage by Dr. Elias' office are done as a courtesy and are not binding and only my insurance company can make a final determination of benefits for my treatment.

X_____ Date: _____

Parent/Guardian signature