Hancock Dentistry, PLLC

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Medical & Dental History Form

Patient Name: _____ (Last) _____ (First) ___ (MI)

_____ (Preferred Name)

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in fairly good health? ◯ Yes ◯ No

Within the past year, have there been any changes in your general health? ◯ Yes ◯ No

What is the date (or approximate date) of your last medical exam?

_____

_____

Your Primary Care Physician's name, address, & phone number:

_____

_____

Do You Have or Have You Ever Had: (Please mark any of the following to indicate YES in response to the question)

- ☐ Been under the care of a physician due to a specific condition?
- ☐ Hospitalization for illness or injury?
- ☐ Heart problems, or cardiac stent within the last six months?
- ☐ History of infective endocarditis?
- ☐ Artificial heart valve, repaired heart defect(PFO)?
- ☐ Artificial prosthesis (joints)?
- ☐ Prolonged bleeding due to a slight cut (INR > 3.5)?
- ☐ Emphysema, sarcoidois?
- ☐ Breathing or sleep problems (i.e. snoring, sinus)?
- ☐ Thyroid, parathyroid disease, or calcium deficiency?
- ☐ Hormone deficiency?
- ☐ High cholesterol or taking statin drugs?
- ☐ Digestive disorders (i.e. gastric reflux)?
- ☐ Osteoporosis/osteopenia (i.e. taking bisphosphonates)?
- ☐ Head or neck injuries?
- ☐ Neurologic problems (attention deficit disorder?
- ☐ Any lumps or swelling in the mouth?
- ☐ Often exhausted or fatigued?
- ☐ Any other conditions, diseases, etc., not listed above that we should be aware of? Please List.

If any of the previous questions are marked, please explain:

Are You:

☐ Female: Taking birth control pills? ☐ Male: Prostate disorders?

WOMEN ONLY: Are you pregnant? ◯ Yes ◯ No

If Yes, when is the due date? _____

List all medications, supplements and or vitamins taken within the last two years.

Please indicate if you have experienced any of the following:

☐ *PREMED	☐ Alcohol Dependency	☐ Alzheimer's	☐ Amoxicillin Allergy
☐ Anemia	☐ Anemia	☐ Angina	☐ Arthritis
☐ Aspirin Allergy	☐ Asthma	☐ Bronchitis	☐ Chemotherapy
☐ Clindamycin Allergy	☐ Codeine Allergy	☐ Diabetes	☐ Digestive Disorders
☐ Dizziness	☐ Drug Addiction	☐ Emotional Problems	☐ Emphysema
☐ Endocarditis	☐ Epilepsy / Seizures	☐ Fainting	☐ Fluoride Allergy
☐ Genital Herpes	☐ Genital Herpes	☐ Glaucoma	☐ Hay Fever / Hives
☐ Headaches	☐ Heart Disease	☐ Heart Murmur	☐ High Blood Pressure
☐ HIV / Aids	☐ Ibuprofen Allergy	☐ Irregular Heart Beat	☐ Jaundice
☐ Keflex Allergy	☐ Kidney Disease	☐ Latex Allergy	☐ Liver Disease
☐ Low Blood Pressure	☐ Lupus	☐ Mental Disorders	☐ MitralValve Prolapse
☐ Nervous Disorders	☐ Osteopenia	☐ Osteoporosis	☐ Pacemaker
☐ Penicillin Allergy	☐ Psychiatric Care	☐ Radiation Treatment	☐ Respiratory Problems
☐ Rheumatic Fever	☐ Rheumatism	☐ Scarlet Fever	☐ Sinus Problems
☐ Stomach Problems	☐ Stroke	☐ Sulfa Drug Allergy	☐ Tetracycline Allergy
☐ Thyroid Disease	☐ Tuberculosis	☐ Tumors	☐ Venereal Disease

Do you have any other allergies not listed above? If so, please list.

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

Dental History

What is your immediate concern for your dental visit today?

How would you rate the condition of your mouth?

Personal History

Please mark any of the following to indicate Yes in response to the question:

- [ ] Are you fearful of dental treatment?
- [ ] Have you had an unfavorable dental experience?
- [ ] Have you ever had complications from past dental treatment?
- [ ] Have you ever had trouble getting numb or had any reactions to local anesthetics?
- [ ] Did you ever have braces, orthodontic treatment or had your bite adjusted?
- [ ] Have you had any teeth removed?

Smile Characteristics

Please mark any of the following to indicate Yes in response to the question:

- [ ] Is there anything about the appearance of your teeth that you would like to change?
- [ ] Have you ever whitened (bleached) your teeth?
- [ ] Have you felt uncomfortable or self conscious about the appearance of your teeth?
- [ ] Have you been disappointed with the appearance of previous dental work?

Bite and Jaw Joint

Please mark any of the following to indicate Yes in response to the question:

- [ ] Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)
- [ ] Do you / would you have any problems chewing gum?
- [ ] Do you / would you have any problems chewing bagels, baguettes, or other hard foods?
- [ ] Have your teeth changed in the last 5 years, become shorter, thinner or worn?
- [ ] Are your teeth crowding or developing spaces?
- [ ] Do you have more than one bite and squeeze to make your teeth fit together?
- [ ] Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?
- [ ] Do you clench your teeth in the daytime or make them sore?
- [ ] Do you have any problems with sleep or wake up with an awareness of your teeth?
- [ ] Do you wear or have you ever worn a bite appliance?

Tooth Structure

Please mark any of the following to indicate Yes in response to the question:

- [ ] Have you had any cavities within the past 3 years?
- [ ] Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?
- [ ] Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?
- [ ] Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth?
- [ ] Do you have grooves or notches on your teeth near the gum line?
- [ ] Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?
- [ ] Do you get food caught between any teeth?

Gum and Bone

Please mark any of the following to indicate Yes in response to the question:

- [ ] Do your gums bleed when brushing?
- [ ] Have you ever been treated for gum disease or been told you have lost bone around your teeth?
- [ ] Have you ever noticed an unpleasant taste or odor in your mouth?
- [ ] Is there anyone with a history of periodontal disease in your family?
- [ ] Have you ever experienced gum recession?
- [ ] Have you ever had any teeth become loose on their own (without an injury)?
- [ ] Have you experienced a burning sensation in your mouth?

☐ **To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.**

Authorization

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

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian:

Signature _____ _____

Date

Relationship to Patient:

Response Date: _____