Fleming Island Center for Dental Excellence

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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.

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

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

- ☐ Have you ever had complications following dental treatment?
- ☐ Are you currently under the care of a physician due to a specific condition?
- ☐ Have you been hospitalized within the last 5 years due to a surgery or illness?
- ☐ Are you currently taking any prescription or non-prescription medications?
- ☐ Do you use tobacco (smoking or chewing)?
- ☐ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

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

_____

_____

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

_____

_____

WOMEN ONLY: Are you pregnant? ◯ Yes ◯ No

If Yes, when is the due date? _____

Please indicate if you have experienced any of the following:

☐ *No PreMed required	☐ *Pre-Med - Amox	☐ *Pre-Med - Clind	☐ *Pre-Med - Other
☐ Afib	☐ Allergy Amoxicillin	☐ Allergy Aspirin	☐ Allergy Clindamycin
☐ Allergy Codeine	☐ Allergy Hydrochlorot	☐ Allergy Latex	☐ Allergy Other
☐ Allergy Penicillin	☐ Allergy Sulfa	☐ Allergy Tetracycline	☐ Allergy Tylenol
☐ Anemia	☐ Arthritis	☐ Artificial Joints	☐ Asthma
☐ Blood Disease	☐ Cancer	☐ Diabetes	☐ Dizziness
☐ Epilepsy	☐ Excessive Bleeding	☐ Fainting	☐ Glaucoma
☐ Hay Fever	☐ Head Injuries	☐ Heart Disease	☐ Heart Murmur
☐ Hepatitis	☐ High Blood Pressure	☐ HIV	☐ Hypoglycemia
☐ Jaundice	☐ Kidney Disease	☐ Liver Disease	☐ Mental Disorders
☐ Migraines	☐ MVP	☐ Nervous Disorders	☐ Other
☐ Pacemaker	☐ Pregnant	☐ Radiation Treatment	☐ Reaction to anesthet
☐ Respiratory Problems	☐ Rheumatic Fever	☐ Rheumatism	☐ Sinus Problems
☐ STD	☐ Stomach Problems	☐ Stroke	☐ Taking Blood Thinner
☐ Taking Plavix	☐ Thyroid Problems	☐ TMJ	☐ Tuberculosis
☐ Tumors	☐ Ulcers	☐ Venereal Disease	

Are you required to take antibiotics prior to dental treatment due to a heart condition or an artificial joint replacement. ◯ Yes ◯ No

If yes what antibiotic do you take? _____

Do you have any other health issues or allergies?

_____

_____

What is the reason for your dental visit today?

_____

_____

General/Referring Dentist's name, address, & phone number:

_____

_____

☐ **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 detal 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).

Relationship to Patient:

Signature _____ **Date** 1: _____

Response Date: ____/____/_____