Divine
Dental Hygiene

Medical and Dental History

Name: _____

Birthday (Month/Day/Year): _____

Phone # (home): _____ Phone # (cell):_____

Address: _____

Email address: _____

Gender (Male/Female/Other): _____

Parent, Guardian, Legal Representative (if applicable):_____

Describe your treatment location, click all that apply.

- ☐ Hard flooring (wood, tile, laminate)
- ☐ 5 feet X 9 feet space (small)
- ☐ 6 feet X 10 feet space
- ☐ Devoted Room (facilities and businesses)
- ☐ Private bathrooms (for clean up)
- ☐ Public bathrooms (for clean up)
- ☐ 0 - 6 stairs to reach location
- ☐ Elevator to reach location
- ☐ Pets or animals

Insurance Information

Insurance Company #1: _____

Plan Member: _____

Members Birthday: _____

Policy # or Group #: _____

ID # or Personal #:_____

Insurance Company #2: _____

Plan Member: _____

Members Birthday: _____

Policy # or Group #: _____

ID # or Personal #:_____

Dental History

Main Dental Concerns: _____

What do you LIKE about getting your teeth cleaned? _____

What do you DISLIKE about getting your teeth cleaned? _____

Last Exam Date: _____

Last Cleaning Date: _____

Tooth Sensitivity

- ☐ Cold
- ☐ Hot
- ☐ Sugar
- ☐ Biting on hard foods
- ☐ During my cleaning
- ☐ Brushing
- ☐ Flossing

TMJ Concerns

- ☐ TMJ muscle tension
- ☐ Jaw pain
- ☐ Jaw pops or cracks
- ☐ Headaches
- ☐ Neckaches
- ☐ Injury to Face, Neck, Jaw
- ☐ Ear Aches
- ☐ Ear Ringing
- ☐ Pinched Neck Nerves
- ☐ Arm Numbness
- ☐ Neck pain
- ☐ Limited Opening

Dental Conditions

- ☐ Implants
- ☐ Braces or Orthodontics
- ☐ Periodontal Disease
- ☐ Gum Surgery or Grafting
- ☐ Grinding Appliances
- ☐ Sleep Apnea Appliance
- ☐ Frequent Cleanings 3-4 mos
- ☐ Wisdom Teeth Surgery

Medical History

Medical Conditions for Premedication

- ☐ I require antibiotics before dental treatment
  - ☐ Prosthetic or Artificial Joint
  - ☐ Artificial Heart Valve
  - ☐ Severe Heart Murmur "regurgitation"
  - ☐ Rheumatic Fever Heart Damage
  - ☐ Heart Surgery
- ☐ I DO NOT require premedication before dental treatment

Allergies

- ☐ Penicillin
- ☐ Aenesthetic
- ☐ Peanuts
- ☐ Latex
- ☐ Metals
- ☐ Animals
- ☐ Hay Fever
- ☐ Other

Medical History (check all that apply past or present)

- ☐ Cardiovascular Disease
- ☐ Heart Surgery
- ☐ Heart Attack
- ☐ Coronary Heart Disease
- ☐ Arteriosclerosis
- ☐ Mitral Valve Prolapse
- ☐ Damaged Heart Valves
- ☐ Congenital Heart Defect
- ☐ Congestive Heart Failure
- ☐ Heart Murmur
- ☐ Angina
- ☐ High Blood Pressure or Low Blood Pressure
- ☐ High Cholesterol or Low Cholesterol
- ☐ Rheumatic Fever Heart Damage
- ☐ Pacemaker or Defibrillator
- ☐ Chest pain or Shortness of Breath
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2 (Insulin or Diet controlled)
- ☐ Joint Replacement
- ☐ Require Premedication
- ☐ Hypothyroidism or Graves Disease
- ☐ Asthma
- ☐ Chronic Bronchitis or Emphysema
- ☐ Nasal Congestion or Sinus Trouble
- ☐ Persistent Cough (more then 3 weeks)
- ☐ Cancer
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Hypothyroidism or Hashimoto's
- ☐ Hyperthyroidism or Graves Disease
- ☐ Eating Disorder or Malnutrition
- ☐ Dietary Restrictions
- ☐ Hepatitis
- ☐ Liver Disease
- ☐ Jaundice
- ☐ Gastric Reflux
- ☐ Stomach Ulcers
- ☐ Gall Bladder problems
- ☐ Kidney Stones
- ☐ Bladder problems
- ☐ Abnormal or Excessive Bleeding
- ☐ Anemia
- ☐ Hemophilia
- ☐ Bruise easily
- ☐ Blood Transfusion
- ☐ Systemic Lupus Erythematosus
- ☐ Rheumatoid Arthritis
- ☐ Osteo Arthritis
- ☐ Communicable Diseases Herpes, HIV/AIDS, Hep C, STD's
- ☐ Antibiotic Resistant Infections (MRSA or C. Diff)
- ☐ Immune System Condition (Epstein-Barr, radiotherapy, chemotherapy, sarcodosis)
- ☐ Auto Immune Disease
- ☐ Seizures or Convulsions
- ☐ Anxiety
- ☐ Depression
- ☐ Behavioural Disorders (ADHD, ODD, Autism)
- ☐ Osteoporosis or Osteopenia
- ☐ Fibromyalgia or chronic pain
- ☐ Nicotine Consumption: Smoking, Chew, Pipe Tobacco, Vaping: Frequency _____
- ☐ Substance Use _____

Other Medical Conditions: _____

Medications, Dosage, Reason:_____

_____

_____

Covid-19 Symptoms and other Communicable Diseases

If you have any of these Covid-19 or other disease symptoms, you must cancel your appointment. Please confirm that you do not have any of these symptoms prior to this first appointment.

- Cough or shortness of breath
- Fever or chills in the last 24 hours
- Loss of taste or smell
- Feeling of unwell or fatigue
- Sore throat
- Nausea or vomiting
- Undiagnosed rash, infection or break in the skin
- Communicable infectious disease (flu, cold, measles, chicken pox, or tuberculosis)
- Recent exposure to COVID-19, positive case exposure
- Recent travel to areas where endemic diseases are present
- Recent travel out of the country in the last two weeks, without Covid-19 PCR test upon return
- Have tested positive for Covid-19 in the past 14 days

☐ I confirm that I do not have any Covid-19 symptoms above.

Date: _____

Patient Name:_____

Parent or Guardian Name (if applicable): _____

Signature Patient (Parent or Guardian) : _____

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