Valentine Dental Care
Medical and Dental Health History Form

Birth Date: _____

Date: _____

Patients Legal name (first and last): _____

Name of previous dentist/location: _____

Date of last dental examination: _____

Date of last cleaning: _____

Why have you come to see us today (e.g. pain, checkup, etc.)? _____

_____

How did you hear about us?_____

Family physician (name, location, contact info, and last visit): _____

_____

Personal Contact Information Update:

Preferred Name:_____ Middle Initial:_____

Home Address:_____ City:_____State:_____ Zip Code:_____

Employer:_____ Work Phone#:_____

Home Phone #:_____ Cell Phone #_____

Emergency Contact Person:_____ Emergency relation:_____

Emergency Contact Person Phone #:_____

E-mail:_____

Social Security Number (billing purposes)_____

I prefer to be alerted for dental appointments by:

_____ Mail

_____ E-Mail (Same as above? ___Y ____N)

_____ Both E-mail and Mail

_____ Phone reminder 1-2 days prior to appointment

Insurance Information

Subscriber name:_____

Subscriber ID#:_____

Group #:_____

Subscriber Employer:_____

Insurance Company Name and Address:_____

_____

_____

Dental Health:

Yes	**No**	
☐	☐	Do you brush your teeth? How often? _____
☐	☐	Do you floss? How often? _____
☐	☐	Are you having any pain or discomfort at this time?
☐	☐	Do your gums bleed while brushing and flossing?
☐	☐	Are your teeth sensitive to hot or cold liquids/foods?
☐	☐	Have you ever experienced any of the following problems with your jaw?

(Circle all that apply): clicking pain difficulty in opening and closing difficulty in chewing

☐	☐	Do you have frequent headaches?
☐	☐	Do you clench or grind your teeth? If yes, when? _____
☐	☐	Have you ever had any orthodontic treatment? If so, do you wear a retainer? _____
☐	☐	Have you ever had facial surgery? If so, when and what area of your face? _____
☐	☐	Have you ever had any type of trauma to your mouth, jaw or face? If yes, describe: _____
☐	☐	Do you wear dentures or partials? If so, date of placement: _____
☐	☐	Do you have any concerns about bad breath odor?
☐	☐	Are you pleased with the appearance of your teeth when you smile?
☐	☐	Are you pleased with the color of your teeth?
☐	☐	Is there any dental treatment you are not happy with?
☐	☐	Are you nervous about dental treatment?

Medical Health:
Are you allergic or have you reacted adversely to any of the following (check all that apply):

_____ Aspirin
_____ Codeine
_____ Nitrous Oxide
_____ Penicillin
_____ Erythromycin
_____ Other antibiotics _____
_____ Latex, Metals, Plastic

____ Ibuprofen
____ Sulfa Drugs, Sulfites, Sulfides
____ Acetaminophen/Tylenol
____ Barbiturates
____ Tetracycline
____ Local Anesthesia (Novocaine)

Please list any other allergies to include medications you are allergic to:

Check any of the following that you have had or have at the present:

_____ Osteoporosis
_____ Heart disease or heart attack
_____ Abnormal blood pressure
_____ Heart murmur/mitral valve prolapse
_____ Rheumatic fever
_____ Heart pacemaker
_____ Heart surgery
_____ Stroke
_____ Kidney disease
_____ History of drug addiction /alcoholism
_____ Arthritis
_____ Anemia
_____ Bleeding disorders
_____ Hay fever
_____ Ulcers
_____ Jaundice
_____ Herpes
_____ Tumor or malignancy
_____ Radiation treatment
_____ Blood transfusion
_____ Fainting
_____ Headaches
_____ Glaucoma
_____ Shingles

____ Bisphosphonate therapy (e.g. Boniva)
____ Asthma
____ Diabetes
____ Thyroid issues
____ Hepatitis A, B, C
____ Hemophilia
____ Epilepsy or seizures
____ Psychiatric treatment
____ Artificial joints
____ Anything not listed
____ AIDS or HIV+
____ Congenital heart lesions
____ Tuberculosis or lung disease
____ Sinus issues
____ Liver disease
____ Infectious mononucleosis (mono)
____ Sexually transmitted/venereal disease
____ Cancer/chemotherapy/radiation
____ Implants/artificial joints
____ Anaphylaxis
____ Allergies (including food)
____ Hard of hearing
____ Sickle cell disease/traits
_____ Hypertension

Other: _____
_____

Major surgeries (type and year): _____
_____
_____
_____

List sports activities: _____
_____
_____

_____

Please list all medications you are currently taking, including prescription drugs, over-the-counter drugs, vitamins, herbal remedies and supplements. Alert dentist if (Two examples are listed below.)

Name of medication	Dosage in mg.	Number of times taken	When (daily, as needed)
i.e. Aleve	275	2x	daily
i.e. Lisinopril	50	1x	as needed

_____
_____
_____
_____
_____
_____

Yes	**No**	
☐	☐	Have you been hospitalized during the past two years?
☐	☐	Have you been asked by your medical doctor to premedicate before any dental treatment?
☐	☐	Have you taken Fen-Phen, Redux or appetite suppressants? If yes, have you seen a physician for a cardiac evaluation?
☐	☐	Do you have any disease, condition or problem not listed?
☐	☐	Do you smoke or use chewing tobacco?
☐	☐	Do you smoke or ingest marijuana?
☐	☐	Do you drink alcohol? If yes, how often and in what quantity?
☐	☐	Do you take Viagra?
☐	☐	Have you ever taken Fosamax or Boniva?

For Women Only:

Yes	**No**	
☐	☐	Are you pregnant? If yes, due date: _____
☐	☐	Are you taking birth control pills?
☐	☐	Could you be pregnant?
☐	☐	Are you nursing?
☐	☐	Hormone replacement?

This form is designed to solicit information typically required to plan treatment. The space below is for you to tell me other information you believe I should take into account when planning your treatment.

_____
_____
_____
_____
_____

If you have any questions about this form or are unsure how to answer any questions, we'd be happy to assist you, please ask!

Authorization: I have reviewed the information on this form and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status I will inform the dentist.

Signed: Date: _____

Patient Review and Update of Form: At each visit please review this form, note any changes, sign and date in the spaces below:

Thank You!