THANKSGIVING POINT DENTAL
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766-5300

# Medical & Dental Health History Form

**Please make sure to read, sign and date the back of this form.*

## Step 1 Dental Health History

| Patient Name (First and Last) | Name of Previous Dentist/Location | Date of Last Exam |
|---|---|---|
| | | |

| YES | NO | |
|---|---|---|
| ☐ | ☐ | 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? |
| ☐ | ☐ | Are your teeth sensitive to sweet or sour liquids/foods? |
| ☐ | ☐ | Have you ever experienced any of the following problems with your jaw? Please circle all that apply: |

Clicking Pain Difficulty in Opening/Closing Difficulty in Chewing

| | | |
|---|---|---|
| ☐ | ☐ | Do you have frequent headaches? |
| ☐ | ☐ | Do you clench or grind your teeth? |
| ☐ | ☐ | Have you ever had any prolonged bleeding following extractions? |
| ☐ | ☐ | Have you had any orthodontic treatment? If so, do you wear a retainer? _____ |
| ☐ | ☐ | Do you wear dentures or partials? If so, date of placement? _____ |
| ☐ | ☐ | Do you have any concerns about bad breathe odor? |
| ☐ | ☐ | Are you pleased with the appearance of your teeth when you smile? |
| ☐ | ☐ | Are you pleased with the color of your teeth? |
| ☐ | ☐ | Are there old fillings or dental treatment that you aren't happy with? |
| ☐ | ☐ | Are you nervous about treatment? |

## Step 2 Medical Health History

Are you allergic or have you reacted adversely to any of the following:

| | | | | |
|---|---|---|---|---|
| ☐ Aspirin | ☐ Erythromycin | ☐ Sulfa Drugs | ☐ Barbiturates | ☐ Local Anesthesia |
| ☐ Codeine | ☐ Penicillin | ☐ Latex | ☐ Tetracycline | ☐ Acetaminophen |
| ☐ Nitrous Oxide | ☐ Other Antibiotics | ☐ Ibuprofen | | |

Do you have any other allergies? If yes, please list.

_____

Check any of the following that you HAVE HAD or HAVE at present:

| | | | |
|---|---|---|---|
| ☐ Heart Disease or Attack | ☐ Stroke | ☐ Hepatitis A | ☐ Artificial Joints |
| ☐ High Blood Pressure | ☐ Kidney Trouble | ☐ Hepatitis B | ☐ Anemia |
| ☐ Heart Murmur | ☐ Drug Addiction | ☐ Hepatitis C | ☐ Arthritis |
| ☐ Rheumatic Fever | ☐ Asthma | ☐ Hemophilia | ☐ AIDS or HIV |
| ☐ Heart Pacemaker | ☐ Diabetes | ☐ Epilepsy or Seizures | ☐ Other |
| ☐ Heart Surgery | ☐ Thyroid | ☐ Psychiatric Treatment | ☐ _____ |

*(please fill out other side)*

## Step 2 Medical Health History Continued...

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 Phen-Fen or appetite suppressants? If Yes, have you seen a physician for a cardiac evaluation?
- ☐ ☐ Do you have any disease, condition or problems not listed? If so, please list. _____
- ☐ ☐ For WOMEN ONLY: Are you pregnant? If pregnant, what month? _____
- ☐ ☐ For WOMEN ONLY: Are you taking birth control pills?
- ☐ ☐ Do you smoke or use tobacco?

## Step 3 Acknowledgement with Consent to Proceed

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

I authorize Dr. Blair I. Losee and/or such associates or assistants as he may designate, to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or adminstration of any sedative (including nitrous oxide), analgesic, other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects which may include but are not limited to, bruising, hematoma, cardiac stimulation, temporary or rarely, permanent numbness, and muscle soreness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or possibly quite painful both during and after completion of treatment. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me as necessary and I have been given the opportunity to ask questions.

## Step 4 Please Sign and Date Below.

Signature of Patient/Legal Guardian Date Relationship to Patient

Signature of Witness Date