Innovative Family Dental Health
Medical/Dental History Form

Patient Information

Patients Last Name:_____First:_____M.I.____Date:_____
Date of Birth: _____ Age:_____ Sex:_____
Address:_____City:_____State:_____Zip:_____
Single:_____ Married:_____Widowed:_____Separated: _____Divorced_____
Occupation:_____ Employer:_____
Business Address:_____City:_____
State:_____Zip:
Home Phone:_____
Cell Phone:_____
Work Phone:_____

In case we cannot reach you:
Person to contact_____ Phone #_____

Responsible Party

Name of person responsible for this account:_____
Relationship to patient:_____
Address:_____City:_____State:_____Zip:_____
Occupation:_____ Employer:_____
Business Address:_____City:_____
State:_____Zip:_____
Home Phone:_____
Cell Phone:_____
Work Phone:_____
Social Security Number:_____

Medical History

Health Quality: □ Good □ Fair □ Poor
Allergies: □ Food □ Drug □ Hayfever □ Asthma □ Other

Has the patient had any of the following: (Please Circle)

Hepatitis
Diabetes
Kidney Problems
Sinus Problems
Immune Disorder
Lip or Tongue Biting
Frequent Headaches
Heart Disease
Bleeding Gums
Arthritis
Speech Impairment
Nail Biting
Cerebral Palsy
Epilepsy
Liver Disease
Latex Sensitivity
Artificial Joints
Radiation Therapy
Cancer
Low Blood Pressure
Anemia
Convulsions/Seizures
Tonsils/Adenoids
Tuberculosis
Rheumatic Fever
Excessive Bleeding
Cold Sores/Fever Blisters
Throat Infections
Mouth Breathing
Hemophilia
Frequent Colds
Thyroid Problems
Dizziness or Fainting
Grinding of Teeth
Thumb/Finger Sucking
Difficult Breathing
Chemotherapy
AIDS/HIV
High Blood Pressure
Leukemia
Sexually Transmitted Diseases

Other; Please Explain:_____

Physician:_____ Office Number:_____

Are You Under Physician's Care At Present? (Y or N)_____ For What:_____

List Medications Regularly Taken & Reason:_____

Do You Use Tobacco? Yes_____ No_____
Do You Use Alcohol, Cocaine Or Other Drugs? Yes_____ No_____
Do You Wear Contact Lenses? Yes No_____

For Women Only:

Are You Pregnant Or Think You May Be Pregnant? Yes_____ No_____
Are You Nursing? Yes___ No_____
Are You On Any Control Pills? Yes_____ No_____

Dental History

Please Circle All That Apply

My Gums Bleed When I Brush/Floss	I Have Had Orthodontic Work
My Teeth Are Sensitive To Hot Or Cold Liquids/Foods	My Teeth Are Sensitive To Sweet Or Sour Liquids/Foods
I Have Pain In One Or More Of My Teeth	I Have Sores Or Lumps In Or Around My Mouth
I Have Frequent Headaches	I Clench Or Grind My Teeth
I Bite My Cheeks Or Lips Frequently	I Have Had Difficult Extractions In The Past
I Have Had Head, Neck Or Jaw Injuries	I Have Had Prolonged Bleeding After An Extraction In The Past

I certify that I have answered the above questions to the best of my ability. I will not hold Innovative family Dental Health or any member of its staff responsible for any errors or omissions that I may have made in the completion of this form. I will take full financial responsibility for any and all records taken, and will pay the cost of x-rays and other records taken at the time of consultation and/or diagnosis.

_____ _____

Signature of Patient (Parent or Guardian if Patient is a Minor) Date