Medical/Dental History Form

BOENNING D.D.S.

Page 1 Date: _____

Although in Dentistry we primarily treat the mouth and all of its structures, the oral cavity is connected to the rest of the body and acts as the Gateway to many of its organ systems. Health problems that you may have or medications that you may be taking could have an important interrelationship with the Dentistry you will receive. Therefore, it is important that you answer all of the pertinent questions. Thank you.

Patient Name: _____ Date of Birth: _____

[ ] Mr. [ ] Mrs. [ ] Miss [ ] Ms. [ ] Dr. Email: _____

Home Address: _____ City: _____

State: _____ Zip code: _____

Phone Numbers:
Home _____ Cell _____ Work _____

[ ] Male [ ] Female Marital Status _____ Social Security # _____

Drivers License # _____ State Issued _____

Employer Name: _____ Occupation: _____

Person responsible for the account is [ ] Self [ ] Spouse [ ] Other _____

Emergency Contact: _____Phone_____

Relationship to Patient _____

Insurance Information:
Are you covered by dental insurance [ ] Yes [ ] No

Subscriber Name: _____ Relation to Patient: _____

Subscriber Date of Birth: _____

Address and phone (if different from patient): _____
_____

Insurance Company and Claims Address: _____
_____

Subscriber Employed by: _____ Business Phone: _____

Subscriber ID # (listed on insurance card): _____ Group # _____

Whom may we thank for referring you? _____

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Oral Health

Reason for today's visit: _____

Date of last dental care and name of former dentist (if you are a new patient to our practice)

_____

Check (✓) if you have had problems with any of the follow

❑ Bad Breath	❑ Loose teeth or broken fillings	❑ Sensitivity when biting
❑ Grinding Teeth	❑ Sensitivity to sweets	❑ Food collection between teeth
❑ Sensitivity to hot	❑ Clicking or popping jaw	❑ Sensitivity to cold
❑ Bleeding gums	❑ Periodontal treatment	❑Sores or growths in your mouth
❑ Root Canals	❑ Cold Sores/Fever Blisters/Herpes	

Is there a specific dental problem that you currently have that is not listed above? _____

_____

How often do you floss? _____ How often do you brush? _____

What type of toothbrush do you currently use? _____

Would you be interested in purchasing an electronic toothbrush? [ ] Yes [ ] No

Would you be interested in straighter teeth? [ ] Yes [ ] No

Would you be interested in whiter teeth? [ ] Yes [ ] No Reducing Snoring? [ ] Yes [ ] No

Personal Health

How would you rate your current health? [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Name and location of your current physician: _____

Date of your last physical exam: _____Date of last blood work _____

Medications/Supplements: Please list all prescription and non-prescription medications, injections/infusions vitamins, home remedies, herbs, and topical creams.

_____ _____ _____

_____ _____ _____

_____ _____ _____

Allergies or reactions to medications: _____

_____

Do you have any food allergies or food sensitivities? [ ] Yes [ ] No

If yes, please explain: _____

Surgical / Hospitalization history: Please list all operations with the dates when they occurred.

_____

_____

Please indicate whether you have had any of the following medical problems and/or family history :

	You	Family		You	Family
Periodontal Disease	[ ]	[ ]	Artificial Heart Valve	[ ]	[ ]
Dental Infections	[ ]	[ ]	Heart Arrhythmia	[ ]	[ ]
Bacterial Endocarditis	[ ]	[ ]	Heart Valve Problem	[ ]	[ ]
Pacemaker	[ ]	[ ]	Rheumatoid Arthritis	[ ]	[ ]
Heart Disease	[ ]	[ ]	Kidney Disease	[ ]	[ ]
Stroke	[ ]	[ ]	Kidney Stones	[ ]	[ ]
High Cholesterol	[ ]	[ ]	Gallbladder Stones	[ ]	[ ]
High Blood Pressure	[ ]	[ ]	Pancreatic Disease	[ ]	[ ]
Pre-diabetes	[ ]	[ ]	Lupus	[ ]	[ ]
Diabetes	[ ]	[ ]	Hepatitis Type _____	[ ]	[ ]
Mini-Stroke or TIA	[ ]	[ ]	Gout	[ ]	[ ]
Atrial Fibrillation	[ ]	[ ]	Sjögren's Syndrome	[ ]	[ ]
Poor blood flow to extremities	[ ]	[ ]	Autoimmune Disorder	[ ]	[ ]
Fibromyalgia	[ ]	[ ]	Thyroid Problems	[ ]	[ ]
Emphysema/COPD	[ ]	[ ]	Depression	[ ]	[ ]
Bleeding/Clotting Problems	[ ]	[ ]	Anxiety/Panic Attacks	[ ]	[ ]
Blood Transfusions	[ ]	[ ]	Migraine Headaches	[ ]	[ ]
Anemia	[ ]	[ ]	Osteopenia/Osteoporosis	[ ]	[ ]
High Red Blood Cell Count	[ ]	[ ]	Blood Clot(legs,arms, lungs)	[ ]	[ ]
Leukemia	[ ]	[ ]	Alcoholism	[ ]	[ ]
Abnormal Platelet Count	[ ]	[ ]	Drug Use	[ ]	[ ]
Stomach Ulcers	[ ]	[ ]	Mental Disability	[ ]	[ ]
Chronic Heartburn	[ ]	[ ]	Sleep Disorder/Sleep Apnea	[ ]	[ ]
Post-Traumatic Stress Syndrome	[ ]	[ ]	Joint Replacement	[ ]	[ ]
STD	[ ]	[ ]	History of HIV or AIDS	[ ]	[ ]
Epilepsy/Seizures	[ ]	[ ]	Other _____		

Cancer [ ] You [ ] Family Explain _____

Pre-medicate with antibiotic prior to dental treatment? [ ] Yes Why?_____

Social History

Tobacco Use

Cigarettes [ ] Never [ ] Quit (date you quit) _____[ ] Current how much per day _____

Other tobacco (check all answers that apply): [ ] Pipe [ ] Cigar [ ] Chewing tobacco
[ ] E-Cigarettes [ ] Marijuana

Number of years you've used this tobacco: _____

Are you interested in quitting? [ ] Yes [ ] No Have you tried to quit in the past? [ ] Yes [ ] No

How many times have you tried to quit? _____ What methods have you tried? _____

Are you exposed to second-hand smoke [ ] Yes [ ] No If yes, for how long? _____

Alcohol use

Do you drink alcohol? [ ] Yes [ ] No

If yes, how many drinks do you consume per week? _____ Alcohol type _____

Does your alcohol consumption have you or others concerned? [ ] Yes [ ] No

Signature: _____ Date: _____

Signature of Parent or Guardian; _____