Soundental
ASSOCIATES, PC

ADULT MEDICAL HEALTH HISTORY

Although dental professionals primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Patient Name (Last, First)_____ DOB:_____ Date:_____

Physician's Name_____Date of last physical exam_____

Physician's Address/phone number_____

Are you under a physician's care now? No □ Yes □_____

Have you ever been hospitalized or had major surgery? No □ Yes □_____

Have you ever had a serious head or neck injury? No □ Yes □_____

Do you have ALLERGIES (medications, foods, metals, etc.)? No □ Yes □_____

Do you have a developmental disability/impairment? No □ Yes □_____

Do you use tobacco/smokeless tobacco/E-Cigarettes? No □ Yes □_____

Are you on a special diet? No □ Yes □_____

Are you taking any medications/supplements (including non-prescription)? What for? No □ Yes □

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Women: Are you Pregnant/Trying to get pregnant? □ Nursing □ Taking birth control pills? □

Per your physician, are you to premedicate before dental procedures? (eg. Amoxicillin) No □ Yes □

If so, for what reason and with what medication?_____

Do you have a history or presently have any of the following:

□ Alzheimer's Disease
□ Anemia
□ Angina
□ Arthritis/Gout
□ Artificial Heart Valve
□ Artificial Joint
□ Asthma
□Autoimmune/Immunosuppressed
□ Bisphosphonates
□ Blood Disorder
□ Breathing Problems
□ Bruise Easily
□ Cancer
□ Cardiac Stents
□ Chemotherapy
□ Cold Sores/Fever Blisters
□ Congenital Heart Disorder
□ Cortisone Medicine
□ Diabetes
□ Dialysis
□ Drug Addiction
□ Emphysema
□ Epilepsy or Seizures
□ Excessive Bleeding
□ Excessive Thirst
□ Fainting Spells/Dizziness
□ Frequent Headaches
□ Glaucoma
□ Hay Fever
□ Heart Attack/Failure
□ Heart Pace Maker/Defibrillator
□ Heart Trouble/Disease
□ Hepatitis A
□ Hepatitis B or C
□ Herpes
□ High/Low Blood Pressure
□ High Cholesterol
□ Hives or Rash
□ HPV test
□ Irregular Heartbeat
□ Jaundice
□ Kidney Problems
□ Leukemia
□ Liver Disease
□ Lung Disease
□ Mental Health Issues
□ Pain in Jaw Joints
□Parathyroid/Thyroid Disease
□ Radiation Treatments
□ Recent Weight Loss/Gain
□ Rheumatism
□ Shingles
□ Sinus Trouble
□ Stomach/Intestinal Disease
□ Stroke
□ Swelling of Limbs
□ Tonsillitis
□ Tuberculosis
□ Tumors or Growths

Have you ever had any serious illness not listed above? No □ Yes □_____

Please explain/other: _____

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ADULT DENTAL HEALTH HISTORY

Patient Name (Last, First)_____ DOB:_____ Date:_____
Date of last dental visit?_____ Last dental cleaning?_____Last full mouth X-Rays?_____
Name of previous dentist_____
Address_____City_____State_____Zip_____

How can we help you today?_____
How often do you have dental exams? _____How often do you have dental cleanings? _____
How often do you brush your teeth? _____How often do you floss your teeth? _____
Do you use water-pik, toothpick, electric toothbrush, other? _____
Do you have fluoride in your water?_____ Do you use rinses or fluoride supplements? _____
Describe your diet_____
Are you unhappy with the appearance of your teeth? No □ Yes □_____
Would you like to keep all of your teeth all of your life? No □ Yes □_____

Do you have a history or presently have any of the following:

□ Nightguard, removable dentures or other appliance?_____For how long?_____

□ Pain, soreness, sensitivity or other discomfort
□ Loose or shifting teeth
□ Headaches/muscle tension
□ Bad breath/bleeding gums
□ Past injuries to teeth/mouth/jaw/head
□ Contact lenses
□ Sores/growths in your mouth

□ Anxiety/issues with previous dental treatment
□ Food getting stuck between teeth
□ History of braces or gum/oral surgery
□ Clicking/popping in jaw joint
□ Negative experience with 'Novocaine'
□ Tobacco/Smokeless Tobacco/E-Cigs
□ Sugar in diet

□ Oral habits (nail/cheek biting, thumb sucking)
□ Grinding or clenching teeth
□ Snoring /sleep apnea
□ Dry mouth
□ Use of nitrous (laughing) gas
□ Alcohol/drug abuse

Please explain:_____

_____

Is there anything else about your dental treatment that you would like us to know? _____

_____

Who may we contact in case of an emergency? Name _____

Relationship_____ Phone #_____

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The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. If there are any changes, I agree to notify the office and treating dental professional.

Consent:

1. I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.
2. The undersigned hereby authorizes the doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.
3. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor may choose and employ such assistance as deemed fit to provide recommended treatment.
4. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1.5% per month finance charge may be added to my account, in addition to any collection charges.
5. I understand that it is my responsibility to advise your office of any changes in the information obtained on this form.

_____ _____

Signature of Patient or Parent/Guardian Date

_____ _____

Please print name Relationship to patient