Medical & Dental History

Patient Name:_____

Date:_____

Although dental personnel 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 information as best you can.

Dental History - Please check if any apply to you.

- ☐ Cankers/Cold sores
- ☐ Breath Odor
- ☐ Headaches
- ☐ Jaws making clicking ,grinding or popping noise
- ☐ Orthodontic concerns (crooked teeth or bite)
- ☐ Snore at night
- ☐ Speech impaired/unusual speech habits
- ☐ Strong Gag Reflex
- ☐ Frequent Vomiting
- ☐ Smoking
- ☐ Chewing Tobacco
- ☐ Teeth Grinding, Clenching
- ☐ Mouth/Gums Bleed
- ☐ Periodontal Disease
- ☐ Orthodontic Treatment
- ☐ Teeth Removed
- ☐ Xerostomia/Dry Mouth

Do you frequently consume carbonated beverages? Yes or No

Are you aware of any dental problems at this time?_____

Have you had any problems or complications with previous dental treatment? If yes, please explain:

_____

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

What products/rinses do you use?_____

If you could change anything about your smile, what would it be?_____

Is there anything we can do to make your dental visit more comfortable?_____

Medical History

Physician Name:_____ Name of Clinic or Facility: _____ _____

Are you currently under the care of a physician? Yes or No If yes, why?_____

Please check any of the following conditions that you have or have had in the past:

- ☐ Abnormal Bleeding
- ☐ ADD
- ☐ ADHD
- ☐ Anemia/Blood Disorder
- ☐ Any Heart Problems
- ☐ Arthritis/Rheumatism
- ☐ Artificial Heart Valve Implant
- ☐ Asthma/Hay Fever/Difficulty Breathing
- ☐ Autism
- ☐ Blood Pressure Problems - High/Low
- ☐ Cancer, Type:_____
- ☐ Chemotherapy/Radiation
- ☐ Diabetes: Type 1 or Type 2, Controlled or Uncontrolled
- ☐ Eating Disorders
- ☐ Epilepsy or Seizures
- ☐ Fainting or Dizzy Spells
- ☐ Frequent Headaches
- ☐ Glaucoma or Light Sensitivity
- ☐ Hearing Impaired
- ☐ Heart Attack/Failure
- ☐ Heart Pacemaker
- ☐ Heart Trouble/Disease
- ☐ Heartburn/GERD
- ☐ Heart Murmur
- ☐ Hepatitis - Circle Type A B C Other_____
- ☐ Herpes/Cold Sores
- ☐ HPV
- ☐ Kidney/Liver Problems
- ☐ Psychiatric Problems
- ☐ Nervous Problems
- ☐ Organ Transplant Type:_____
- ☐ Osteopenia or Osteoporosis
- ☐ Prosthetic Joint Replacement Type:_____
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tested positive for HIV
- ☐ Thyroid: Hypothyroid / Hyperthyroid
- ☐ Tuberculosis
- ☐ Sleep Apnea - CPAP Y or N
- ☐ STD

Have you ever had a disease condition, serious illness or major surgery not listed above? Yes or No
If yes, please explain:_____

Is there a family history of Diabetes, Heart Disease, Oral Cancer, or Periodontal Disease? Yes or No
If yes, please explain:_____
_____

Do you regularly consume two or more alcoholic drinks a day or use recreational drugs? Yes or No
If yes, please explain:_____
_____

Please list any prescribed/over the counter medications you are taking: *(Bring Copy if more space needed)*
Medication Name: _____Condition: _____
Medication Name: _____Condition: _____
Medication Name: _____Condition: _____
Medication Name: _____Condition: _____
Medication Name: _____Condition: _____
Medication Name: _____Condition: _____

Please list any vitamins or natural supplements you are currently taking:
_____
_____

Are you **ALLERGIC** to any of the following?

- ☐ Aspirin
- ☐ Ibuprofen
- ☐ Sulfa Drugs
- ☐ Penicillin
- ☐ Codeine
- ☐ Latex, Metals, Plastics
- ☐ Local Anesthetics
- ☐ Food Allergy _____
- ☐ Others _____
  _____

Women: Are you pregnant? Unsure ☐ Yes☐ No☐ Nursing? Yes☐ No☐

Terms and Conditions

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

I authorize release of any information concerning my healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits or another dentist.

I authorize and consent to the taking of photographs before, during, and after treatment. I further give permission for the use of those photographs for the purpose of research and education.

I understand that I am responsible for all costs of dental treatment.

I understand that I have a right to my dental records and that there may be a fee associated with receiving such records.

I hereby authorize payment of insurance benefits directly to the dentist or dental group.

Mishicot Dental does not accept any patients with insurance through the State of Wisconsin, such as Badger Care, Medical Assistance, Title 19, Forward, etc. By signing this form, I am stating that I am not covered under any state dental plan.

I attest that the above information is complete and accurate.

Signed: _____ Date: _____
Patient or Guardian Signature

Signed: _____ Date: _____
Doctor Signature