Patient Medical History

Patient's Name _____

Physician _____ Office Phone _____ Date of Last Exam _____

	Yes	No
1. Are you being treated for any medical conditions?	☐	☐
2. Have you had any surgeries, joint replacements or valve replacements?	☐	☐
3. Are you taking any medication(s) including non-prescription medicine? If yes, what medication(s) are you taking? _____	☐	☐
4. Do you use tobacco?	☐	☐
5. Do you use controlled substances?	☐	☐
6. Are you wearing contact lenses?	☐	☐

7. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure	☐	☐	Heart Disease	☐	☐	Chest Pains	☐	☐
Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded	☐	☐
Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke	☐	☐
Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever/Allergies	☐	☐
Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis	☐	☐
Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy	☐	☐
Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma	☐	☐
Epilepsy/Convulsions	☐	☐	Cancer	☐	☐	Recent Weight Loss	☐	☐
Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease	☐	☐
Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble	☐	☐
Kidney Diseases	☐	☐	Hepatitis/Jaundice	☐	☐	Respiratory Problems	☐	☐
AIDS or HIV Infection	☐	☐	Sexually Transmitted Disease	☐	☐	Mitral Valve Prolapse	☐	☐
Thyroid Problem	☐	☐	Stomach Troubles/Ulcers	☐	☐	Other_____	☐	☐

8. Are you allergic to or have you had any reactions to the following:

	Yes	No
Local Anesthetics (eg. Novocaine)	☐	☐
Penicillin or any other Antibiotics	☐	☐
Sulfa Drugs	☐	☐
Barbiturates	☐	☐
Sedatives	☐	☐
Iodine	☐	☐
Aspirin	☐	☐
Any Metals (eg. nickel, mercury etc.)	☐	☐
Latex Rubber	☐	☐
Other _____	☐	☐

9. Women Only:

Are you pregnant or think you may be pregnant?	☐	☐
Are you nursing?	☐	☐
Are you taking oral contraceptives?	☐	☐

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No
1. Have you been diagnosed with gum/periodontal disease?	☐	☐
2. Do your gums bleed while brushing or flossing?	☐	☐
3. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
4. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
5. Do you feel pain to any of your teeth?	☐	☐
6. Do you have any sores or lumps in or near your mouth?	☐	☐
7. Have you had any head, neck or jaw injuries?	☐	☐
8. Have you ever experienced any of the following problems in your jaw?	☐	☐
Clicking/Popping	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
9. Do you have a history of prolonged bleeding?	☐	☐
10. Do you have frequent headaches?	☐	☐
11. Do you clench or grind your teeth?	☐	☐
12. Have you had any orthodontic treatment?	☐	☐
13. Do you wear dentures or partials?	☐	☐
14. Do you like your smile?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

I consent to dental treatment at Valley Dental Care.

X _____

Signature of patient (or parent if minor)

Patient Information

Date _____

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Date of Birth _____ Social Security # _____

Cell Phone _____ Email _____

How did you hear about Valley Dental Care? _____

Responsible Party Information

Name _____ _____
Last First Middle Marital Status

Mailing Address _____
Street City State Zip

Home Phone _____

Cell Phone _____ Email _____

Insurance Information

Subscriber Name _____ Subscriber Date of Birth _____

Subscriber Employer _____

Insurance Company _____ Group No. _____ Member No. _____

Insurance Co. Address _____

Do you have dual coverage? Yes ☐ No ☐ If yes:

Subscriber Name _____

Subscriber Employer _____

Insurance Co. _____ Group No. _____ Member No. _____

Insurance Co. Address _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____

Phone _____

I hereby consent to dental treatment by Valley Dental Care.

Signature (Parent's signature if minor) _____

CONFIDENTIAL (for record and pretreatment evaluation)