HIGHLAND DENTAL CLINIC

# CONFIDENTIAL PATIENT MEDICAL & DENTAL HISTORY

*Last* *First* *(Preferred)*

Patient Name: _____

*Day* *Month* *Year*

DOB:

_____ Gender: Male , Female or Non-binary: (please circle)

Address: _____

City: _____ Postal Code: _____ Prov: _____

Mobile Phone: _____ Home Phone: _____

Email: _____

Occupation: _____ Employer: _____

Family Doctor Name: _____ Phone Number: _____

Emergency Contact Name & Relation_____ Phone Number: _____

How did you hear about us? _____

**Dental Insurance Information:**

*Primary Insurance*

Policy/Group #: _____

ID #: _____

Policy Holders Name:_____

Policy Holders Birthdate: _____

Policy Holders Employer: _____

*Secondary Insurance*

Policy/Group #: _____

ID #: _____

Policy Holders Name:_____

Policy Holders Birthdate: _____

Policy Holders Employer: _____

***If you have dental insurance, please present your ID and insurance information to the front desk.***

## MEDICAL HISTORY

1. Are you currently in good health, ☐ Yes ☐ No

Are you currently being treated for any medical condition or have you been treated within the past year? Please explain:

_____

1. When was your last medical checkup? _____

2. Are you under the regular care of or waiting for an appointment for a medical specialist?. ☐ Yes ☐ No

If yes, please explain: _____

1. Are you currently taking any medications, vitamins, non-prescription drugs or herbal supplements? If yes, please list.

_____

1. Do you have any allergies or have you ever had an unusual/adverse reaction to the following: (Please circle):

Medications (Please list): _____

Injections/Dental anesthetic Penicillin Codeine Aspirin Sulfa Drugs Latex/Rubber Other: _____

1. Do you currently smoke, vape, use marijuana or tobacco/nicotine products? ☐ yes ☐ no

If yes, which ones and for how long _____

1. Do you bleed longer than normal after a cut, bruise, surgery, or previous tooth removal, or do you have a bleeding problem/disorder? ☐ Yes ☐ No
If yes, please explain: _____

2. Have you ever had a serious illness, operation, or been hospitalized for an illness or operation? ☐ Yes ☐ No

If yes, please explain: _____

9. Women: Are you pregnant or breastfeeding? ☐ Yes ☐ No If pregnant, what trimester _____

Continued on back...

10. Is there a language barrier or comprehension challenge that we should be aware of? ☐ Yes ☐ No _____

## MEDICAL HISTORY - CONTINUED

11. Do you currently have or have you ever had any of the following conditions? Please circle all that apply:

☐ Artificial / Prosthetic Joint

☐ Heart trouble / pacemaker / heart murmur

☐ High or low blood pressure

☐ Heart Attack / Angina

☐ Heart valve replacement/repair, heart infection (endocarditis), congenital heart disease, or heart transplant

☐ Breathing problems / asthma

☐ Arthritis

☐ Hepatitis / jaundice / liver disease

☐ HIV positive / immune-system disorder

☐ Diabetes

☐ Thyroid disorder / hormonal disorder

☐ Kidney disease

☐ Tuberculosis

☐ Cancer / Radiation / Chemotherapy

☐ Epilepsy / seizures

☐ Rheumatic fever

☐ Osteoporosis / Bone Disease

☐ A.D.H.D. / A.D.D.

☐ Mental illness

☐ Autism / Spectrum Disorder

☐ GERD / acid reflux / Heart Burn

☐ Cold sores

☐ Blood disorders

☐ Other:

12. Is there anything else we should know about your health, medications, or medical history? ☐ Yes ☐ No If yes, please explain:

_____

## DENTAL HISTORY

Reason for Today's Visit: _____

1. How frequently do you see your dentist? (Please check one) ☐ 6 months ☐ 9 months ☐ Annually ☐ Emergency Only

Former Dentist/Clinic Name: _____

**Date of last visit:** **Last cleaning** **Last examination:**

2, Were X-rays taken at your last dental visit: ☐ Yes ☐ No If yes please give approximate date: _____

3. What are your goals for your teeth and oral health? (Please check all that apply)

Pain Management ☐Function ☐ Health and Longevity ☐ Aesthetics

4. How often do you brush _____. floss _____ your teeth?

5. Are any of your teeth sensitive to? ☐ Cold ☐ Hot ☐ Sweet ☐ Other

6. Do you notice any of the following: ☐ Bleeding Gums ☐ Swelling/Gum Ache ☐ Receding Gums ☐ Loose Teeth

7. Are you aware or have been told that you clench or grind your teeth? ☐ Yes ☐ No.

8. Do you wear a night guard, appliance or CPAP at night? ☐ Yes ☐ No

9. Do you notice any of the following in your jaw joint or muscles? ☐ Pain ☐ Popping/Clicking ☐ Bite misalignment ☐ Frequent Headaches/Migraines

10. Are you interested in or have you thought about any of the following regarding your oral health: (Please circle all that apply)

Improved Gum Health

Botox - esthetic or TMJ pain

Orthodontics/ Invisalign (straightening teeth)

Replacing Missing Teeth

Sports Mouthguard

Tooth Whitening (Bleaching)

Improving Breath Odor

Improving Smile Esthetics

11. Do you have any concerns about visiting the dentist? (Please check all that apply)

Fear/Anxiety ☐ Time ☐ Cost ☐ Embarrassment ☐ Gag reflex ☐ Previous bad experience

12. How do you rate yourself as a dental patient? ☐ Calm ☐ Slightly Nervous ☐ Very Nervous

13. Are you interested in any form of sedation for dental treatment? ☐ Yes ☐ No.

14. Have you had any complications or unusual reactions during previous dental treatment or tooth removal? ☐ Yes ☐ No

If yes, please explain. _____

15. Is there anything else about your dental health or treatment preferences that you would like us to know? ☐ Yes ☐ No. If yes, please explain:

_____

*I certify that the above medical and dental history is true to the best of my knowledge. I agree to provide my dentist and/or hygienist with any updates or changes to the above information at any future appointments. I consent to the performing of dental procedures at Highland Dental Clinic as discussed and advised including but not limited to dental X-rays and local anesthetic.*

**Patient / Parent / Guardian Signature** _____ **Date** _____