# Dentistry West

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## New Patient Medical & Dental History Form

**Patient Name:** _____ _____ ___ _____
Last First MI Preferred Name

**Date of Birth:** _____

**Would you consider yourself to be in fairly good health?** ◯ Yes ◯ No

**Within the past year, have there been any changes in your general health?** ◯ Yes ◯ No

**What is the date (or approximate date) of your last medical exam?**

_____

_____

**Your Primary Care Physician's name, address, & phone number:**

_____

_____

**Please mark any of the following to indicate Yes in response to the question:**

☐ Have you ever had complications following dental treatment?
☐ Are you currently under the care of a physician due to a specific condition?
☐ Have you been hospitalized within the last 5 years due to a surgery or illness?
☐ Do you use tobacco/nicotine (smoke, chew or vaping)?

**If any of the previous questions are marked, please explain:**

_____

_____

**Are you pregnant?** ◯ Yes ◯ No

**If Yes, when is the due date?** _____

Please indicate if you have experienced any of the following:

| | | | |
|---|---|---|---|
| ☐ Acid reflux/digestive issues | ☐ Allergy | ☐ Antibiotic premedication needed | ☐ Anxiety, depression |
| ☐ Arthritis | ☐ Artificial Joints | ☐ Asthma, COPD, Emphysema | ☐ Atrial fibrillation (AFib) |
| ☐ Autoimmune Disease | ☐ Bleeding issues | ☐ Cancer | ☐ Diabetes |
| ☐ Dizziness/Vertigo | ☐ Excessive Bleeding | ☐ Headaches/migraines | ☐ Heart Disease |
| ☐ High Blood Pressure | ☐ Immunocompromised | ☐ Kidney Disease | ☐ Latex Allergy |
| ☐ Liver Disease | ☐ Osteoporosis | ☐ Pacemaker | ☐ Seizures |
| ☐ Sinus Problems | ☐ Sleep Apnea (CPAP) | ☐ Stroke | ☐ Surgery |
| ☐ TMD/TMJ | ☐ Tuberculosis | | |

**List any other health related issues:**

_____

_____

**List any allergies, including allergies to medications:**

**List any medications or supplements that you are currently taking:**

**Do you need to be pre-medicated with antibiotics before dental appointments?** ◯ Yes ◯ No

**What is the reason for your dental visit today?**

**Prior dentist name and date of last visit (or approximate date):**

**What was done on your last dental visit?**

**How frequently do you brush your teeth?**

◯ 3 (+) a day ◯ Twice a day ◯ Once a day ◯ Weekly ◯ Seldom

**How frequently do you floss your teeth?**

◯ 1 (+) a day ◯ 2 - 6 weekly ◯ 1 - 6 monthly ◯ Seldom ◯ Never

**Please mark any of the following to indicate Yes in response to the question:**

☐ Do your gums bleed when you brush or floss?

☐ Do your teeth experience sensitivity to cold or hot temperatures?

☐ Are any of your teeth currently causing you pain?

☐ Do you grind your teeth (either consciously or during sleep)?

☐ Are any of your teeth loose, or are you concerned about any teeth loosening?

☐ Do you currently have any dental implants, dentures, or partials?

**If any of the previous questions are marked, please explain:**

**If you could change anything about your mouth, teeth, or smile, what would it be?**

☐ **To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental visit.**

**Authorization**

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian:

Signature _____ **Date** _____

**Relationship to Patient:** _____

Dentist's Signature:

Signature _____ **Date** _____

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**Response Date:** _____