# Indian River Family Dentistry, PLLC

P.O. Box 459 • Indian River, MI 49749 (231)238-9346

## Medical & Dental History Form

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

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

**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:**

_____

_____

**Are you currently taking any prescripton or non-prescripton medications?** ◯ Yes ◯ No

**Please list medications**

_____

_____

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

☐ Have you ever had complications following dental treatment?

☐ Do you require antibiotics before dental treatment?

☐ Have you been hospitalized within the last 5 years due to a surgery or illness?

☐ Do you use tobacco (smoking or chewing)?

☐ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

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

_____

_____

**WOMEN ONLY: Are you pregnant?** ◯ Yes ◯ No

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

Please indicate if you have experienced any of the following:

- ☐ *No Chronic Disease
- ☐ Allergy- Anesthetics
- ☐ Allergy- Sulfa
- ☐ Angina
- ☐ Blood Disease
- ☐ Cold Sores/Herpes
- ☐ Epilepsy/Seizures
- ☐ Head Injuries
- ☐ Heart Murmur
- ☐ HIV
- ☐ Morphine
- ☐ Pt on oxygen
- ☐ Sinus Problems
- ☐ Tuberculosis
- ☐ *No known allergies
- ☐ Allergy- Clindamycin
- ☐ Allergy-other
- ☐ Arthritis
- ☐ Blood Thinners
- ☐ Dementia
- ☐ Excessive Bleeding
- ☐ Heart Attack
- ☐ Heart Valve Replaced
- ☐ Immunosuppression
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Stomach Problems
- ☐ Tumors/Growths
- ☐ *Premed*
- ☐ Allergy- Codiene
- ☐ Allergy-Penicillin
- ☐ Artificial Joints
- ☐ Blood Transfusion
- ☐ Diabetes
- ☐ Fainting/Dizziness
- ☐ Heart defect- congen
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Pregnancy
- ☐ Respiratory Problems
- ☐ Stroke
- ☐ Ulcers
- ☐ Allergy- Amoxicillin
- ☐ Allergy- Latex
- ☐ Anemia
- ☐ Asthma
- ☐ Cancer
- ☐ Drug/Alcohol Abuse
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Liver Disease
- ☐ Psychiatric Problems
- ☐ Rheumatic Fever
- ☐ Transplant
- ☐ Venereal Disease

**Do you have any other health issues or allergies not listed above?**

_____

_____

_____

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

_____

_____

**When was your last visit to the dentist (if to a different office)?**

_____

_____

**What was done on your last dental visit (if to a different office)?**

_____

_____

**Prior Dentist's name, address, & phone number:**

_____

_____

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

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

**What type of bristles?**

◯ Hard ◯ Medium ◯ Soft

**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 now or have you ever experienced pain /discomfort in your jaw joint? (TMJ/TMD)
- ☐ 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 detal appointment without fail.**

**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:**

_____

_____

_____

**Response Date:** ___/___/_____