MEDICAL HISTORY

Print Patient's Name: _____ Date of Birth _____
(First Middle Last)

Check the dentist you wish to see: ☐ **Ed Fernandez, Jr., D.M.D.** ☐ **John F. Sigman, D.M.D.**

Answer all questions - sign and date below.

I. PERSONAL HISTORY

Medical Doctor's Name _____ Previous Dentist's Name _____ Date of Last Dental Exam _____

II. MEDICAL HISTORY

Circle yes or no

yes no 1. Are you now under the care of a physician?
a. If so, what is the condition being treated? _____

My last physical exam was on _____

yes no 2. Have you been hospitalized or had a serious illness within the past five (5) years? If so, what was the problem? _____
_____ When? _____

yes no 3. Have you undergone chemotherapy treatment in the last ten(10) years?

yes no 4. Are you taking ANY drug, medicine, or pills? (prescription or over the counter) If so, what? _____
_____

yes no 5. Are you being treated for osteoporosis with a bone building prescription drug?

yes no 6. Have you ever been told to be premedicated with antibiotic before dental treatment?

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

yes no a. rheumatic fever or rheumatic heart disease

yes no b. congenital heart lesions or heart murmur

yes no c. cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure)

yes no d. Bypass surgery or cardiac prostheses (heart valve)

yes no e. mitral valve prolapse

yes no f. "pacemaker" Date: _____

yes no g. epilepsy or seizures

yes no h. diabetes (controlled insulin or diet)

yes no i. hepatitis, jaundice or liver disease

yes no j. tuberculosis (active ☐ passive ☐ Date tx completed _____)

yes no k. have you ever tested positive to HIV? (AIDS) date _____

yes no l. Are you pregnant at this time? Due date _____

yes no m. Hip or other joint replacement

yes no n. Kidney disease

yes no o. Handicaps

yes no p. Other_____

yes no 8. Have you had abnormal bleeding associated with previous extraction, surgery or trauma?

yes no 9. Have you had surgery or x-ray treatment for a tumor, growth or other conditions? (other than diagnostic)

10. Are you allergic or have you ever acted adversely to:

yes no a. local anesthetics (novocaine)

yes no b. penicillin

yes no c. sulfa drugs

yes no d. barbituates, sedatives, or sleeping pills

yes no e. aspirin

yes no f. iodine

yes no g. codeine

yes no h. nitrous oxide

yes no i. erythromycin

yes no j. other antibiotics_____

yes no k. Latex_____ other_____

III. DENTAL HISTORY

11. Reason for present visit (chief complaint)? _____

12. Approximate date of last dental exam? _____

yes no 13. Are your teeth painful? If so, describe _____

yes no 14. Have you ever been told that you have gum disease (pyorrhea)? If yes, when_____

yes no 15. Have you ever had gum (periodontal) treatment? If yes, date and by whom? _____

16. How often do you brush your teeth? _____

17. IS there anything about your smile you would like to change? _____

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 accuratly 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 payers, 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.

X _____ *Date:* _____

Signature of patient (or parent/guardian if minor)