MORGAN
FAMILY DENTAL

Patient Dental & Medical Health History Information

To our patients: Please understand that we may ask follow-up questions to make sure we have all of the information we need. Our goal is to provide you with the highest quality of care possible. Please print or write legibly.

PATIENT INFORMATION • SIDE • A

PATIENT INFORMATION

Last Name: **First Name:** **Middle Initial:**

Main Phone: **Cell Phone:** **Work Phone:**

Mailing Address: **City:** **State:** **Zip:**

Email Address: **DOB:** **Soc Sec #:**

Gender: M ☐ F ☐ Prefer not to answer ☐ **Preferred method of communication:** Phone ☐ Text ☐ Email ☐

Marital Status: M ☐ S ☐ D ☐ W ☐ **Spouse's Name:** **Spouse's Phone:**

Emergency Contact Name: **Relationship:** **Phone:**

If you are completing this form for another person, what is your name and relationship to that person?

Name: _____ **Relationship:** _____

Who may we thank for referring you to us? **Name:** _____

Did you find us on your own? Y ☐ N ☐

Occupation: _____

Are you currently experiencing any dental pain or discomfort? Y ☐ N ☐ **If yes, where?** _____

DENTAL HISTORY & SYMPTOMS

Please "CHECK" the box(s) below ONLY if they apply to you.

Have you ever had periodontal (gum) treatments (scaling / root planing)? ☐

If yes, when and at which dental office? _____

_____

_____

Does your jaw click, pop or hurt? ☐

Do you have earaches or neck pain? ☐

Are you unhappy with your smile? ☐

If yes, why? Please mark all that apply:

☐ The color of my teeth ☐ The shape of my teeth ☐ The position of my teeth

☐ Other (Please describe): _____

_____

_____

_____

_____

HIPAA RELEASE INFO

Can we discuss your dental care with another individual? Y ☐ N ☐ **If yes, please list name(s) below.**

_____

FINANCIAL CONSENT

I agree to pay for services that are not covered, or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance.

X _____ **X** _____

SIGNATURE **DATE**

MEDICATIONS & OTHER PRODUCTS / SUBSTANCES

Please write your answers to the following questions below. Yes No

Do you take any **PRESCRIPTIONS AND/OR OVER-THE-COUNTER MEDICINE(S), VITAMINS, HERBS AND/OR SUPPLEMENTS**? ☐ ☐

If yes, please list them here. _____

_____

_____

_____

Are you taking any blood thinners (i.e., Coumadin, Warfarin, rivaroxaban (Xarelto®), dabigatran (Pradaxa®), clopidogrel (Plavix®)? ☐ ☐

Do you use any form of **tobacco or nicotine products** (cigarettes, cigars, chewing tobacco), **vaping, uncontrolled substances, or recreational drugs)**? ☐ ☐

CURRENT & PAST MEDICAL CONDITIONS

Are you currently under the care of a physician? ☐ Yes ☐ No **If yes, for which condition(s)?** _____

_____

Physician's or Clinic Name: _____ **Phone:** _____

Please write your answers to the following questions below. Yes No

Has a physician recommended that you take **antibiotics** before having dental treatment? ☐ ☐

If yes, which one(s)? _____

Have you had any type of **joint replacement**, either total or partial surgery (such as for a hip, knee, shoulder, etc.)? ☐ ☐

Have you had a **heart valve replacement or heart surgery**? ☐ ☐

Have you ever been diagnosed with **oral cancer**? ☐ ☐

Have you had a **serious illness, operation or been hospitalized** in the past 5 years? ☐ ☐

HEALTH CONDITIONS

Please "CHECK" below to select your answers to the following questions.

Do you have, or have you been diagnosed with, any of the following conditions?

	Yes	No		Yes	No		Yes	No
ADD/ADHD	☐	☐	Dry Mouth	☐	☐	Low Blood Pressure	☐	☐
Allergies	☐	☐	Epilepsy	☐	☐	Mental Health	☐	☐
Angina	☐	☐	Fainting Spells	☐	☐	Migraines	☐	☐
Anxiety	☐	☐	Frequent Headaches	☐	☐	Mitral Valve	☐	☐
Arthritis	☐	☐	GE Reflux	☐	☐	Pacemaker	☐	☐
Artificial Bones	☐	☐	HIV/AIDS	☐	☐	Pain in Jaw Joints	☐	☐
Artificial Heart	☐	☐	Heart Attack	☐	☐	Radiation Therapy	☐	☐
Asthma	☐	☐	Heart Disease	☐	☐	Rheumatic Fever	☐	☐
Autism	☐	☐	Heart Surgery	☐	☐	Seizures	☐	☐
Cancer	☐	☐	Hepatitis B	☐	☐	Sinus Problems	☐	☐
Colitis	☐	☐	High Blood Pressure	☐	☐	Stroke	☐	☐
Congenital Heart	☐	☐	High Cholesterol	☐	☐	Thyroid Problems	☐	☐
Depression	☐	☐	Joint Replacement	☐	☐	Tuberculosis	☐	☐
Diabetes	☐	☐	Kidney Problems	☐	☐	Ulcers	☐	☐
Difficulty Breathing	☐	☐						

FOR WOMAN

Please "CHECK" below to mark your answers.

Pregnant? Y ☐ N ☐

Nursing? Y ☐ N ☐

Birth Control? Y ☐ N ☐

ALLERGIES

Please "CHECK" below to mark all that apply.

☐ Aspirin	☐ Erythromycin	☐ Metal	☐ Tetracycline
☐ Codeine	☐ Jewelry	☐ Milk	☐ **OTHER**
☐ Dental Anesthetics	☐ Latex	☐ Penicillin	_____

MEDICAL INFORMATION • SIDE • B