COLLINGWOOD DENTISTRY

MEDICAL & DENTAL HISTORY FORM

Patient Name: **Title:**

Gender: ☐ Male ☐ Female **Status:** ☐ Married ☐ Single ☐ Child ☐ Other

Birth Date: **Email Address:**

Phone # **Alternate #**

Address:

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 in good health? Yes ☐ No ☐
- Within the last year, have there been any changes in your health? Yes ☐ No ☐
- When was your last medical exam?
- Please tell us your primary care physician's name, address & phone number.
- Please only mark off the ones you would answer with YES:

Have you had any complications following dental treatment in the past? ☐

Are you currently under the care of a physician due to a specific condition? ☐

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

Are you currently taking prescription or non-prescription medications? ☐

Do you use tobacco (smoking OR chewing)? ☐

Do you require the use of corrective lenses (Contact OR glasses)? ☐

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

COLLINGWOOD DENTISTRY

MEDICAL & DENTAL HISTORY FORM

IF YOU ANSWERED "YES" TO ANY OF THE ABOVE QUESTIONS PLEASE EXPLAIN BELOW:

WOMEN ONLY

- Are you pregnant? Yes ☐ No ☐

  If yes, provide due date:

- Please indicate if you have experienced any of the following:

☐ Pre-Medication	☐ Allergy-Codeine	☐ Allergy-Iodine	☐ Allergy-Aspirin
☐ Allergy-Latex	☐ Allergy-Penicillin	☐ Allergy-Sulfa	☐ Allergy-Erythromicin
☐ Allergy-Local	☐ Anesthetic	☐ Arthritis	☐ Artificial Joints
☐ Asthma	☐ Blood Thinner	☐ Cancer	☐ Diabetes
☐ Dizziness	☐ Emphysema	☐ Epilepsy	☐ Excessive Bleeding
☐ Bruising	☐ GI Issues	☐ Glaucoma	☐ Hard to Freeze
☐ Hay Fever	☐ Head Injury	☐ Hearing Disabled	☐ Heart Disease
☐ Heart Murmur	☐ Hepatitis A	☐ Hepatitis B	☐ Hepatitis C
☐ High Cholesterol	☐ HIV+ (AIDS)	☐ Hives	☐ Jaundice
☐ Kidney disease	☐ Liver disease	☐ Mental Disorders	☐ MS
☐ Nervous disorders	☐ Pacemaker	☐ Respiratory Issues	☐ Sinus Problems
☐ STD's	☐ Skin Rash	☐ Thyroid Disorder	☐ TMJ
☐ Tuberculosis	☐ Tumors	☐ Ulcers	☐ Wheelchair

- Do you have any other health issues or allergies?

COLLINGWOOD DENTISTRY

MEDICAL & DENTAL HISTORY FORM

- What is the reason for your visit today?

- When was your last visit to a dentist?

- What was done at your last visit?

- Prior dentists name, address and phone number?

- How often do you brush your teeth?

☐ 3+ Daily ☐ Twice Daily ☐ Once Daily ☐ Weekly ☐ Seldom

- How often do you floss?

☐ 1+ Daily ☐ 2-6 Weekly ☐ 1-6 Monthly ☐ Seldom ☐ Never

- Do your gums bleed when you brush? Yes ☐ No ☐
- Do your teeth experience sensitivity to hot or cold temperatures? Yes ☐ No ☐
- Are any of your teeth causing you pain? Yes ☐ No ☐
- Do you grind your teeth? Yes ☐ No ☐
- Are any of your teeth loose? Yes ☐ No ☐
- Do you have any implants, dentures or partials? Yes ☐ No ☐

COLLINGWOOD DENTISTRY

MEDICAL & DENTAL HISTORY FORM

- If you answer yes to any of the above questions, please explain below:

- If you could change one thing 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 notify the office at my next dental 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 dependant(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 services provided the day said services are performed. In the event I have insurance coverage, and my insurance company will allow it, I understand that my claim can be electronically sent to my provider for direct reimbursement, otherwise it is my responsibility to submit the claim. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependants (if any).

☐ I hereby acknowledge there is a missed appointment charge of $100.00 for every 15 minutes reserved for me, UNLESS I provide 48 hours notice of a cancellation.

Signature of patient, parent or guardian: **Date:**

Relationship to Patient: