# Destin Harbor Dental

**Medical History Form**

**Patient Name:**_____ **Birth Date:**_____ **Best Phone Number:**_____

PLEASE READ CAREFULLY AND ANSWER EACH QUESTION AS ACCURATELY AS POSSIBLE: Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

What is your impression of your present health?_____ Date of your last medical physical?_____

Physician's Name and Phone Number:_____

DO YOU HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING?

| | | | | |
|---|---|---|---|---|
| □ AIDS/HIV Positive | □ Chemotherapy | □ Hypoglycemia | □ Rheumatism | □ Excessive Bleeding |
| □ Alzheimer's disease | □ Chest Pains | □ Irregular Heartbeat | □ Recent Weight Loss | □ Renal Dialysis |
| □ Anemia | □ Cold Sores/Fever Blisters | □ Kidney Problems | □ Shingles | □ Ulcers |
| □ Angina | □ Congenital Heart Disorder | □ Genital Herpes | □ Leukemia | □ Sickle Cell Disease |
| □ Arthritis/Gout | □ Glaucoma | □ Liver Disease | □ Sinus Trouble | □ Fainting Spells/Dizziness |
| □ Artificial Heart Valve | □ Yellow Jaundice | □ Hay Fever | □ Thyroid Disease | □ Spina Bifida |
| □ Artificial Joint | □ Cortisone Medicine | □ Heart Attack/Failure | □ Lung Disease | □ Stroke |
| □ Asthma | □ Diabetes | □ Heart Pacemaker | □ Mitral Valve Prolapse | □ Swelling of Limbs |
| □ Blood Disease | □ Drug Addiction | □ Heart Trouble/Disease | □ Osteoporosis | □ Low/High Blood Pressure |
| □ Blood Transfusion | □ Hemophilia | □ Venereal Disease | □ Rheumatic Fever | □ Cancer |
| □ Breathing Problems | □ Emphysema | □ Hepatitis A | □ Psychiatric Care | □ Tuberculosis |
| □ Bruise Easily | □ Epilepsy/Seizures | □ Hepatitis B or C | □ Radiation Treatments | □ Tumors or Growths |

HAVE YOU EVER HAD ANY SERIOUS ILLNESS NOT LISTED? □Yes □No If Yes:_____

Are you presently, or have you been under the care of a physician during the past? □Yes □No If Yes:_____

Are you presently taking any medication or drugs □Yes □No If Yes:_____

Have you ever taken Fosamax, Boniva, Actonel or any other medications? □Yes □No If Yes:_____

Are you on a special diet? □Yes □No If Yes:_____

Have you ever been told you were not eligible to be a blood donor? □Yes □No If Yes:_____

Have you ever had any complications with a local anesthetic? □Yes □No If Yes:_____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING? □ Aspirin □ Codeine □ Metal □ Sulfa Drugs □Penicillin □ Acrylic □ Latex

□ other medicine and/or materials:_____

**Do you use tobacco?**□Yes □No Frequency:_____ Smoke: □ Cigarettes □ Cigars □ Pipe Smokeless: □ Chewing tobacco □ Snuff or "dip" □Vapor

**Women:** Are you Pregnant? □Yes □No Trying to get pregnant? □Yes □No Nursing? □Yes □No Taking oral contraceptives? □Yes □No

**Date of your last visit to the dentist:**_____ **Date of last Full Mouth X-Rays:**_____ **Pano:**_____ **Bitewings:**_____

**Name, Address and Phone Number of your previous Dentist:**_____

**Authorization and Release:** I certify that I have read and understand the above information to the best of my knowledge. The above questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients) health. It is my responsibility to notify the dental office of any changes in medical status. I authorize the dentist to release information including the diagnosis and 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.

Signature of Patient, Parent or Guardian:_____ Date:_____

Dentist's Comments

Blood Pressure_____ Date_____ Blood Pressure_____ Date_____ Blood Pressure_____ Date_____

Reviewer_____ Date_____ Reviewer_____ Date_____ Reviewer_____ Date_____

Dentist's Sign _____ Date_____ Dentist's Sign _____ Date_____ Dentist's Sign _____ Date_____