LINK FAMILY DENTISTRY

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Patient Medical/Dental History

Although dental personnel primarily treat the area in and around your mouth, your mouth is 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 receive. Thank you for answering the following questions.

Physician _____ Office Phone _____ Date of Last Exam _____

1. Are you under medical treatment now? ☐ Yes ☐ No
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? ☐ Yes ☐ No
   If yes, please explain _____
3. Are you taking any medication(s) including non-prescription medicine or supplements? ☐ Yes ☐ No
   If yes, what medications are you taking? _____
4. Are you currently or have you ever taken osteoporosis medications in the past? ☐ Yes ☐ No
   If so how long? _____
   Which ones? _____
5. Do you use tobacco? ☐ Yes ☐ No
6. Do you use controlled substances or recreational drugs? ☐ Yes ☐ No
7. Are You Allergic to:

Local Anesthetics (e.g. novocaine)	☐ Yes	☐ No
Penicillin	☐ Yes	☐ No
Other Antibiotics _____	☐ Yes	☐ No
Sulfa Drugs	☐ Yes	☐ No
Sedatives	☐ Yes	☐ No
Aspirin	☐ Yes	☐ No
Ibuprofen	☐ Yes	☐ No
Tylenol	☐ Yes	☐ No
Codeine	☐ Yes	☐ No
Any Metals (e.g. nickel, mercury, etc.)	☐ Yes	☐ No
Latex Rubber	☐ Yes	☐ No
Other _____	☐ Yes	☐ No

8. Women Only -
   Are you pregnant or think you may be pregnant? ☐ Yes ☐ No

Do you have or have you had any of the following?

Acid Reflux	☐ Yes	☐ No	Congestive Heart Failure	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
AIDS or HIV Infection	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No
Anaphylaxis	☐ Yes	☐ No	Easily Winded	☐ Yes	☐ No	Joint Replacement or Implant	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Emphysema / COPD	☐ Yes	☐ No	Kidney Diseases	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Endocarditis	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Arrhythmia	☐ Yes	☐ No	Epilepsy / Seizures	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Fainting	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No
Artificial Heart Value	☐ Yes	☐ No	Frequently Tired	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Radiation Therapy	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Hay Fever / Allergies / Sinus	☐ Yes	☐ No	Recent Weight Loss	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Hearing / Sight Impaired	☐ Yes	☐ No	Stomach Troubles / Ulcers	☐ Yes	☐ No
Cardiac Pacemaker	☐ Yes	☐ No	Heart Attack	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Chest Pains	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Cold Sores	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Congenital Heart Disease	☐ Yes	☐ No	Hepatitis / Jaundice	☐ Yes	☐ No	Vertigo	☐ Yes	☐ No

Have you ever had any serious illness not listed above? _____

Patient Dental History

Name of Previous Dentist/Location _____ Date of Last Exam/Cleaning _____

Date of last x-rays _____ X-ray type _____

1. Do your gums bleed while brushing or flossing? ☐ Yes ☐ No
2. Are your teeth sensitive to hot or cold liquids/foods? ☐ Yes ☐ No
3. Are your teeth sensitive to sweet or sour liquids/foods? ☐ Yes ☐ No
4. Do you feel pain to any of your teeth? ☐ Yes ☐ No
5. Do you have any sores or lumps in or near your mouth? ☐ Yes ☐ No
6. Have you had any head, neck or jaw injuries? ☐ Yes ☐ No
7. Have you ever experienced any of the following problems in your jaw?
   - Clicking ☐ Yes ☐ No
   - Pain (joint, ear, side of face) ☐ Yes ☐ No
   - Difficulty in opening or closing ☐ Yes ☐ No
   - Difficulty in chewing ☐ Yes ☐ No
8. Do you have frequent headaches? ☐ Yes ☐ No
9. Do you clench or grind your teeth? ☐ Yes ☐ No
10. Do you bite your lips or cheeks frequently? ☐ Yes ☐ No
11. Have you ever had any difficult extractions in the past? ☐ Yes ☐ No
12. Have you ever had any prolonged bleeding following extractions? ☐ Yes ☐ No
13. Have you had any orthodontic treatments? ☐ Yes ☐ No
14. Do you wear dentures or partials? ☐ Yes ☐ No
    If yes, date of placement _____
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums? ☐ Yes ☐ No
16. Do you like your smile? ☐ Yes ☐ No

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 accurately 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 agree to be responsible for payment of all service rendered on my behalf of my dependents.

Attn: See front desk staff to sign this form and HIPAA forms on the computer signature pad. Thank you.