KENNEWICK DENTAL PATIENT MEDICAL AND DENTAL HISTORY

MEDICAL

Patient Name:_____Date of Birth:_____
Physician Name:_____ Phone:_____
Date of last physical exam:_____ Are you under the care of a physician now? ❒ **YES** ❒**NO**
If **yes**, please explain: _____
Have you ever been hospitalized, and if so for what?_____

CIRCLE any of the following conditions you have or have had in the past:

Heart Failure	Artificial Joints/Prosthesis	Fainting/Dizzy Spells	Hay Fever
Heart Disease or Attack	Anemia	Nervousness	Sinus Trouble
Chest Pain	Stroke	Depression	Allergies/Hives
High Blood Pressure	Kidney Trouble/Disease	Psychiatric Treatment	Diabetes
Heart Murmur	Hepatitis	Sickle Cell Disease	Thyroid Disease
Mitral Valve Prolapse	Liver Disease	Glaucoma	Arthritis
Rheumatic Fever	Yellow Jaundice	Chemotherapy	Cortisone Medicine
Heart Defects	Blood Transfusion	(Cancer/Leukemia)	Pain in Jaw Joints
Scarlet Fever	Drug Addiction	Venereal Disease	HIV Positive
Artificial Heart Valve	Hemophilia	Bruise Easily	AIDS
Heart Pacemaker	Fever Blisters	Emphysema	Loss of Appetite
Heart Surgery	Epilepsy or Seizures	Asthma	Loss of Sleep
Osteoporosis			

CIRCLE any of the following medications you are allergic to or that have caused reactions:

Aspirin	Local Anesthetic (Novocain)	Valium
Nitrous Oxide	Codeine	Penicillin
Percodan	Erythromycin	Sulfa

List any other medications that you are knowingly allergic to or have had a bad reaction to:_____
List any medications you are currently taking: _____
_____

Are you currently **pregnant**, trying to get pregnant, or **nursing**? (PLEASE CIRCLE) ❒ **YES** ❒ **NO**
Are you currently taking Birth Control Pills? ❒ **YES** ❒ **NO**
Are you taking any medications for **Osteoporosis**? ❒ **YES** ❒ **NO**
Is there any other medical information not included above which you feel we should be informed about? ❒ **YES** ❒ **NO**
If **yes**, please explain:_____

DENTAL

1. What prompted you to seek dental care at this time?_____
2. How long has it been since your last thorough dental examination? _____
3. When were your teeth last cleaned? _____ X-rayed? _____
4. Has the fear of discomfort kept you from regular dental visits? _____
5. Are you satisfied with your past dentistry? _____
6. Have you had any bad experiences in a dental office? _____
7. Are you troubled with bad breath? _____
8. Do your gums bleed easily, feel tender or irritated? _____
9. Have you been diagnosed with gum disease or had a deep cleaning in the past?_____
10. Are your teeth sensitive to hot, cold or sweets? _____
11. Do you often have sores or fever blisters in your mouth? _____
12. Are there areas in your mouth where food sticks or gets caught? _____
13. Are you self-conscious about the appearance of your teeth? _____
14. Do your jaws often feel tired or sore? _____ If yes, when do you notice this feeling? _____
15. Do you experience excessive headaches and/or pain in the neck, shoulders or back? _____
16. Do you experience clicking or popping noises when opening or closing your mouth, or when chewing food? _____
17. Are you aware of grinding or clenching your teeth? _____
18. Do you smoke or use Tobacco products? _____if yes, how much?_____
19. **What, if anything, would you do to change the appearance of your teeth?** _____
_____

CONSENT

I acknowledge that all of the above information is accurate to the best of my knowledge. I hereby authorize Madder, Barney, DMD, PLLC and/or their trained staff to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs. I also authorize Madder, Barney, DMD, PLLC and/or Their trained staff to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents will be used when indicated and that this embodies a certain risk. I hereby give my permission to release any medical/dental information which may be indicated to process insurance claim forms or to receive proper treatment from other health specialists.

_____ _____ _____
Signature of Patient / Parent or Guardian Dr. Signature Date