Associates in Dentistry

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NEW PATIENT MEDICAL HISTORY

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____* (Last) _____* (First) ____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:*** ◯ Male ◯ Female **Family Status:*** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date:* _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____* (Home) _____ (Mobile) _____ (Work) _____ (Ext) _____ (Fax) _____ (Other)

Address: _____* (Address 1) _____ (Address 2)

_____* (City) _____* (State) _____-_____* (Zip Code)

In an emergency who should be notified? Please enter name and phone number below: *

_____

_____

Health Information

Please review the following medical conditions and select the box to the left of those conditions that apply to you.

☐ *AIDS (HIV Positive)	☐ *AIDS (HIV)	☐ *Alcohol	☐ *Allergies
☐ *Arthritis	☐ *Artificial Joints	☐ *Asthma	☐ *Blood Disease
☐ *Blood Thinners	☐ *BP (Anemia)	☐ *BP (Bleeding)	☐ *BP (High)
☐ *Cancer (Chemo)	☐ *Cancer (Radiation)	☐ *Diabetes	☐ *Dizziness
☐ *Epilepsy	☐ *Fainting	☐ *Glaucoma	☐ *Head Injuries
☐ *Heart (Congenital)	☐ *Heart (Rheumatic)	☐ *Heart Angina	☐ *Heart Attack
☐ *Heart Condition	☐ *Heart Murmur	☐ *Heart Trouble	☐ *Hepatitis A
☐ *Hepatitis B	☐ *Hepatitis C	☐ *Kidney Disease	☐ *Liver Disease
☐ *Mental Disorders	☐ *Nervous Disorders	☐ *Pacemaker	☐ *Pregnancy
☐ *Respiratory Issues	☐ *Sinus Problems	☐ *Smoke	☐ *Stomach Problems
☐ *Stroke	☐ *Tuberculosis	☐ *Tumors/Growths	☐ *Ulcers
☐ *Vape	☐ *Venereal Disease	☐ *Well Water	

If you have any additional medical conditions not listed above or need to add any details or clarification, please explain:

_____

_____

_____

_____

_____

_____

If you are currently not taking any medications, please say "None".

Please list any medications you are currently taking, one medication per line:

Have you been admitted to a hospital or had a serious illness during the past 5 years? * ◯ Yes ◯ No

If yes, please explain why and when you were admitted to the hospital:

Are you under the care of a physician? * ◯ Yes ◯ No

If yes, please provide the name and phone number of the physician:

Have you ever or do you currently take a antibiotic premedication prior to your dental visits? * ◯ Yes ◯ No

If yes, please explain why you have or currently take premedication:

When was your last dental appointment? _____

What is the reason you left your previous dentist?

Do you have any concerns you would like addressed at your upcoming appointment? * ◯ Yes ◯ No

If yes, please describe:

Have you ever been told you have gum disease (gingivitis/periodontitis)? * ◯ Yes ◯ No

Have you ever had a "deep cleaning" (scaling and root planing)? * ◯ Yes ◯ No

Have you ever received orthodontic treatment? * ◯ Yes ◯ No

If yes, are you satisfied with the results?

Do you have missing teeth? * ◯ Yes ◯ No

If yes, please describe (how long they have been missing, etc.):

Do you have any type of removable prosthetics, such as dentures or partials? * ◯ Yes ◯ No

☐ * **By checking this box, I acknowledge that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and dental staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of the dental staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.**

Thank you for taking the time to fill out this on-line form. The signature below will be captured during your next appointment at Greg Nairn, DMD.

Signature _____ **Date** _____

Response Date: _____