-/Jackson Dental Clinic

Dental & Medical History Information

Dental History

Patient Name _____ _____ _____
Last Name First Name Middle Initial

DOB: _____ SS# _____

Address _____ APT # _____

City, State _____ Zip Code _____

Home phone: _____ Cell Phone: _____Email:_____
Insurance Co. Name:_____ Ins ID#:_____ Ins Co. phone #:_____
Employer Name(Insurance Purposes for group plan): _____

Reason for today's visit_____ Date of last dental visit_____
Date of last dental x-rays_____ Date of last cleaning_____

Check (√) if you have or have had any of the following:
☐**Bad Breath** ☐**Grinding teeth** ☐**Sensitivity to hot** ☐**Sensitivity to sweets** ☐**Bleeding Gums**
☐**Loose teeth or broken fillings** ☐**Periodontal treatment** ☐**Sensitivity when biting** ☐**Sensitivity to cold**
☐**Clicking or popping jaw** ☐**Food collection between teeth** ☐**Sores or growths in your mouth**

How often do you brush?_____ How often do you floss?_____

Medical History

Physician's Name_____ Phone number_____ Date of last visit_____

Females Only: Are you pregnant? ☐Yes ☐No

Have you ever taken any medications containing bisphosphonates? This includes brands such as Fosomax, Actonel, Didronel, Boniva, Aredia, and Zomets. ☐Yes ☐No

Are you on a Blood Thinner? ☐Yes ☐No

Please check all that apply:
☐AIDS/HIV ☐Artificial Heart Valves ☐Artificial Joints ☐Bleeding abnormally, with extractions or surgery
☐Cancer, Type_____ Date_____ ☐Chemotherapy, Date_____ ☐Radiation, Date_____
☐Congenital Heart Lesions ☐Congestive Heart Failure ☐Diabetes ☐Heart Disease ☐Heart Murmur/MVP
☐Hepatitis, Type_____ ☐Herpes ☐High Blood Pressure ☐Jaw Pain ☐Kidney Disease ☐Liver Disease
☐Nervous Problems ☐Pace Maker ☐Psychiatric Care ☐Weight Loss/Gain ☐Stroke ☐Heart Attack
☐Thyroid Problems ☐Tuberculosis ☐Tumor or growth on head or neck ☐Ulcer ☐Venereal Disease
Joint Replacement: Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ☐Yes ☐No
Date:_____ If yes, have you had any complications?_____
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐Yes ☐No

Allergies: ☐Aspirin ☐Codeine☐Dental Anesthetics☐Erythromycin☐Latex ☐Metals☐Penicillin☐Iodine
☐Sulfa drugs ☐Tetracycline☐Local anesthetics☐Narcotics ☐Other:_____

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Date _____ **Signature** _____