HANOVER DENTAL CARE

Adult Medical and Dental History

Patient Name _____D.O.B. _____ Emergency Contact (Name/Phone #) _____

Medical History

1. Physician_____Phone Number_____
2. When was your last physical examination? _____
3. Are you under the care of a physician? ..... □Yes □No
If yes, for what reason(s)? _____
4. Are you presently taking any medications/drugs/pills/herbals/supplements? ..... □Yes □No
If yes, please list: _____
5. (Women) Is there a chance you are pregnant? ..... □Yes □No If yes, anticipated due date? _____
6. Do you take oral contraceptives? ..... . □Yes □No
7. Are you allergic/sensitive to: □None □Codeine □Penicillin □Local Anesthetic □Latex □Pine Nuts □Dyes □Other: _____
8. Do you smoke, chew tobacco, or use E-cigarettes? ..... □Yes □No
If yes, please indicate which one(s), daily frequency, and how long? _____
9. Do you have Diabetes? ..... □Yes □No If yes, please indicate: □Type 1 □Type 2 Last HbA1c date and level: _____
10. Do you have, or have you ever had:

Abnormal blood pressure.....	□Yes □No	Heart pacemaker	□Yes □No
Anemia	□Yes □No	Heart surgery	□Yes □No
Arthritis	□Yes □No	Heart trouble	□Yes □No
Artificial heart valve/stent/graft.....□Yes □No		Hepatitis (Type __)	□Yes □No
Artificial joint replacements	□Yes □No	HIV positive/AIDS	□Yes □No
Asthma	□Yes □No	Jaundice	□Yes □No
Cancer	□Yes □No	Kidney trouble/Dialysis	□Yes □No
Chemical dependency	□Yes □No	Leukemia	□Yes □No
Chemotherapy/radiation	□Yes □No	Oral herpetic lesions	□Yes □No
Congenital heart defects	□Yes □No	Treatment w/Bisphosphonates….	□Yes □No
Corticosteroid treatment	□Yes □No	Psychiatric care	□Yes □No
Epilepsy/seizures	□Yes □No	Rheumatic fever	□Yes □No
Excessive or prolonged bleeding ..	□Yes □No	Sexually transmitted infection	□Yes □No
Fainting spells	□Yes □No	Sinus trouble	□Yes □No
Glaucoma	□Yes □No	Stroke	□Yes □No
Hearing impaired .....□Yes □No		Thyroid problem	□Yes □No
Heart murmur	□Yes □No	Tuberculosis or Lung Disease …	□Yes □No
Ulcers/GERD	□Yes □No		

11. Do you take pre-medication for anything? ..... □Yes □No If you pre-medicate, what for? _____
12. Have you had any other serious illness, hospitalization or accident? ..... □Yes □No If yes, please explain: _____

(Over Please)

Dental History

1. Former Dentist_____ Address_____
Phone Number_____
2. When did you last visit a dentist? _____When was your last cleaning? _____
X-rays taken? ..... □Yes □No
If yes, □Full Mouth Series □Bitewings □Panoramic
What was done at your last visit? _____
Why did you leave that dentist? _____
Has any dental treatment been recommended to you that you have not had done? _____
3. Are you aware of any dental problems ..... □Yes □No
If yes, please explain: _____
4. Please rate the present condition of your mouth: **Poor** 1 2 3 4 5 6 7 8 9 10 **Excellent**
5. Have you ever been treated for gum disease? ..... □Yes □No If yes, what was done? _____
6. Do you have well water? ..... □Yes □No
7. Is your water fluoridated? ..... □Yes □No
8. Are your teeth sensitive to: □Nothing □Sweet □Cold □Heat □Pressure
9. Please rate the appearance of your smile: **Poor** 1 2 3 4 5 6 7 8 9 10 **Excellent**
10. Would you like a whiter smile? ..... □Yes □No
11. Would you like straighter teeth?..... □Yes □No
12. Have you had your teeth straightened/worn braces? ..... □Yes □No
13. Are you concerned with bad breath (malodor)? ..... □Yes □No
14. Are you concerned with snoring or sleep apnea? ..... □Yes □No
15. Are you concerned with grinding or clenching your teeth (bruxism)? ..... □Yes □No
16. Do you wear a bite guard? ..... □Yes □No
17. Are you aware of possible TMJ problems? (Does your jaw joint make noise, lock up, or create pain?)
..... □Yes □No
18. Is there anything else that would be valuable for your dentist to know to best care for you?_____
_____

□ I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

□ I authorize the release of any information concerning my (or my child's) healthcare, advice, and treatment to another dentist.

□ I have accurately advised my dental care provider of my current health status and any dietary or herbal supplements, medications, and/or drugs (including recreational and over the counter) that I am taking or have taken in the last week.

Patient Signature _____ Date_____
(Parent/Guardian)

Dentist Signature _____ Date_____