Medical-Dental History

Patients name____
Sex _______M ______F Birthdate ___________________________________
If you are filling out this form for the above named patient, what is your relationship to this patient? ____
The following information must be completed so your dental treatment may be completed without endangering your health. If you are unsure or have questions please discuss them with Dr. Pico.

MEDICAL ALERT

Physicians Name___________________________________
Physicians Phone Number ___________________________

MEDICAL HISTORY

HAVE YOU EVER HAD OR CURRENTLY HAVE: (please write yes or no)

Allergies to any drugs or medications? ___________________Specify__________________________
Are you presently taking any medications or drugs? _____________(Attach separate list if several)
Describe: ____
Are you presently under the care of a physician? ____
Have you ever been hospitalized? _____________________Reason______________________________
Blood pressure, Stroke or Heart problems? ____
Heart Murmur or Rheumatic fever? ____
Asthma, Hay Fever, Sinusitis? ____
Diabetes, Liver, Kidney, Thyroid, or Lung problems? _____________________________________
Stomach problems or ulcers? ____
Hepatitis or Jaundice? ____
Epilepsy or nervous disorders? ____
Bleeding or blood clotting disorders? ____
Arthritis or Rheumatism? ____
Radiation treatments or chemotherapy? ___ ____
Venereal disease, HIV or AIDS? ____
Psychiatric Treatment? ____
Any other illness that you are aware of? ____
WOMEN: Are you pregnant? _________ How many months? __________ weeks __________
Are you taking birth control medication?_____________________________________

DENTAL HISTORY

Date of last dental visit ____
What is your chief dental concern? ____
Do you currently have any dental problems? ____
Do your gums bleed? ____
Have you ever been treated for periodontal disease? _______________________________________
Do you have any loose teeth? ____
Are any teeth sensitive to hot/cold? ____
Do you grind your teeth? ____
Does your jaw pop or click? ____
Have you ever had any complications following dental treatment? ___________________________
Any other problems not mentioned? ____
I have answered the above questions accurately and I authorize AZ Dental Health Inc. to release my Dental/Medical history to other practitioners or third party payors as he deems necessary.

Patient/Guardian Signature ___________________________________Date________________