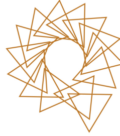

PEGGY BOWN
DENTISTRY

# Medical and Dental History Form

**Patient Information**

Name: ___________________________________________________ Birthdate: ______________________
Address: ________________________________ City: ________________ Prov: _________ PC:___________
Home phone: ______________ Work #: _____________ Cell #: ______________ E-Mail: _________________
Sex: ☐ M ☐ F Marital status: ☐ Single ☐ Married ☐ Child ☐ Partnership
Employer or school: ________________________________________ Phone: ___________________________
Address: ________________________________ City: ________________ Prov: _________ PC:___________
Spouse, partner or parent name: ______________________________________________________________
Person to contact in case of an emergency: ____________________________ Phone: __________________
Whom may we thank for referring you? ___________________________________________________________

**Dental Insurance**

Insurance company: ________________________________________ Phone: ___________________________
Group # ___________________________ ID# _____________________________________________________
Whose name is the insurance under? ___________________________________________________________

**Secondary Dental Insurance**

Insurance company: ________________________________________ Phone: ___________________________
Group # ___________________________ ID# _____________________________________________________
Whose name is the insurance under? ___________________________________________________________

**Dental History**

Reason for today's visit: ______________________________________________________________________
Date of last dental hygiene appointment: ______________________________________________________

Check if you have any problem with the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Canker sores
- ☐ Food collection between certain teeth
- ☐ Grinding teeth
- ☐ Headaches
- ☐ Jaw pain
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold, hot, sweets or brushing
- ☐ Sensitivity when biting
- ☐ Snoring
- ☐ Sores or growth in your mouth

**Medical History**

Your physician: ______________________________________ Date of last visit: ___________________
Have you had any serious illness or operations? ☐ Yes ☐ No
If yes, describe: ____________________________________________________________________________
Have you been tested for sleep apnea? ☐ Yes ☐ No
Have you had your tonsils/adenoids removed? ☐ Yes ☐ No
Women only: Are you pregnant? ☐ Yes ☐ No
Are you nursing? ☐ Yes ☐ No

Check if you have or have had any of the following:

- ☐ Anemia
- ☐ Arthritis, rheumatism
- ☐ Artificial heart valves
- ☐ Artificial joints, pins, etc.
- ☐ Asthma/respiratory disease
- ☐ Bleeding abnormally
- ☐ Blood disease
- ☐ Cancer
- ☐ Chemical dependency
- ☐ Chemotherapy/radiation
- ☐ Circulatory problems
- ☐ Congenital heart lesions
- ☐ Diabetes
- ☐ Eating disorders
- ☐ Epilepsy
- ☐ Fainting
- ☐ Heart murmur
- ☐ Heart problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ HPV
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Mitral valve prolapse
- ☐ Pacemaker
- ☐ Rheumatic/scarlet fever
- ☐ Stroke
- ☐ Thyroid problems
- ☐ Tobacco use
- ☐ Tuberculosis

List medications you are currently taking and the correlating diagnosis:

| Medication (including vitamins) | Diagnosis |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

Please list any allergies you may have:

| Allergy | Allergy |
|---|---|
| | |
| | |
| | |
| | |

**Authorization**

I hereby certify that I have read and understand the previous information and that is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third party insurance carriers, payers, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent or guardian:

Signature: ___________________________________________________ Date: ______________________

Relationship to patient, (if not self): ______________________________ Response date: _______________