MEDICAL & DENTAL HISTORY

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RAMSEY A. AMIN D.D.S. TARA

Today's date:

Name: Last First MI Preferred Name

Phone: Home Cell Work

( ) ( ) ( )

Address: City: State: Zip:

Occupation: Email: Date of Birth: Sex: ☐ M ☐ F

SS#: Emergency Contact - Name: Relationship: Phone (w/Area Code) Home: Cell:

If you are completing this form for another person, what is your relationship to that person?

Your Name: Relationship:

DENTAL INFORMATION

Please mark an (x) to your responses to the following questions:

What is the reason for your dental visit today?

	Yes	No
Do your gums bleed when you brush or floss?	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐
Does food or floss catch between your teeth?	☐	☐
Are any of your teeth loose?	☐	☐
Do you have any broken teeth?	☐	☐
Is your mouth dry?	☐	☐
Have you had periodontal (gum) treatments?	☐	☐
Have you had orthodontic (braces) treatment?	☐	☐
Are you fearful of dentistry?	☐	☐
Have you had trouble getting or staying numb in the past?	☐	☐

	Yes	No
Do you gag easily during dental work?	☐	☐
Are you currently experiencing dental pain or discomfort?	☐	☐
Do you have bad breath?	☐	☐
Do you have earaches or neck pains?	☐	☐
Do you have clicking, popping or discomfort in the jaw?	☐	☐
Do you clench or grind your teeth?	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐
Do you wear removable dentures or partials?	☐	☐
Have you ever had a serious injury to your head or mouth?	☐	☐

Date of your last dental visit: What was done at that time?

How often do you floss? What type of toothpaste do you use? How frequently do you brush?

Have you had any problems associated with previous dental treatment? ☐ Yes ☐ No

Explain:

If you are fearful of dentistry and would like to be sedated (sleeping) for dental work, what makes you nervous?
Check all that apply, so the doctor can discuss with you:

☐ Needles ☐ Cleanings ☐ Drilling Sounds ☐ Smells
☐ Anticipation of pain ☐ Gagging ☐ Surgery ☐ Everything!

SMILE EVALUATION

Please mark an (x) to your responses to the following questions:

With recent advancements in materials and techniques, many of our patients are asking questions about advanced dental procedures. In order to better serve you, please take a moment and let us know how you feel about the appearance of your smile.

	Yes	No
Do you like the appearance of your teeth?	☐	☐
Are your teeth as straight as you would like them to be?	☐	☐
Are your teeth as white as they could be?	☐	☐
Are you happy with the length, width and shape of your teeth?	☐	☐
Do you think you have a gummy smile?	☐	☐
Do you have any missing teeth, besides your wisdom teeth?	☐	☐
Are your teeth chipped, broken or worn down?	☐	☐

	Yes	No
Do you have spaces between your teeth?	☐	☐
Do you have any discolorations, stains or spots on your teeth?	☐	☐
Do you have any dental work that you do not like?	☐	☐
Do you have any mercury silver fillings that you would like changed to white?	☐	☐
Has anyone you have known had any cosmetic or implant dentistry done that interests you?	☐	☐

If you could change anything about your mouth, teeth or smile, what would it be?

MEDICAL INFORMATION

Please mark an (x) to your responses to the following questions:

	Yes	No
Are you in good health?	☐	☐
Are you under the care of a physician?	☐	☐

Physicians Name: _____

Phone (w/area code): (_____) _____

Address/City/State/Zip: _____

Has there been any change in your general health within the past year?	☐	☐

If yes, what condition is being treated:

_____

Date of last medical exam: _____

Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐

If yes, what was the illness or problem:

_____

Are you taking or have you taken any diet drugs, such as phen-fen ?	☐	☐
Are you taking or have you EVER, even once, taken medications, such as alendronate (Fosamax), risedronate (Actonel), or Boniva for osteoporosis or Paget's disease?	☐	☐

	Yes	No
Since 2001, were you treated or are you scheduled to begin treatment with the intravenous biphosphonates (aredia or Zometa) for bone pain, hypercalcermia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐

Date treatment began: _____

Do you use any recreational drugs (such as marijuana)?	☐	☐
Do you use tobacco (smoking, snuff, chew)?	☐	☐

If so, how interested are you in stopping?
Check one:
☐ Very ☐ Somewhat ☐ Not Interested

Do you drink alcoholic beverages?	☐	☐

If yes, how much do you typically drink in a week?

_____

WOMEN ONLY Are you:

Pregnant?	☐	☐

Number of weeks: _____

Taking birth control pills or hormonal replacement?	☐	☐
Nursing?	☐	☐
Anticipating becoming pregnant?	☐	☐

MEDICATIONS: Do you take any prescription or over the counter medications? ☐ Yes ☐ No (If yes, please list all, including herbals):

_____

Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? ☐ Yes ☐ No

Date: _____ If yes, have you had any complications? _____

Allergies: Are you allergic to or have had a reaction to: (to all YES responses, specify type of reaction)?

	Yes	No
Local anesthetics	☐	☐
Ibuprofen (Motrin) (Advil)	☐	☐
Penicillin or other antibiotics	☐	☐
Sedatives or sleeping pills	☐	☐
Sulfa drugs	☐	☐
Codeine, Demerol or other narcotics	☐	☐
Metals	☐	☐
Latex (rubber)	☐	☐
Iodine	☐	☐
Hay Fever/Seasonal	☐	☐
Tetracycline or Clindamycin	☐	☐
Food	☐	☐
Other	☐	☐

Please mark an (x) to indicate if you have or have not had any of the following diseases or problems:

	Yes	No
01. Heart murmur	☐	☐
02. Mitral valve prolapse	☐	☐
03. Artificial heart valves	☐	☐
04. Rheumatic fever/ disease	☐	☐
05. Cardiovascular disease	☐	☐
06. Angina (Chest Pain)	☐	☐
07. Arteriosclerosis (hardening of the arteries)	☐	☐
08. Congestive heart failure	☐	☐
09. Coronary artery disease	☐	☐
10. Damaged heart valves	☐	☐
11. Heart attack	☐	☐
12. Low blood pressure	☐	☐
13. High blood pressure	☐	☐
14. Congenital heart defects	☐	☐
15. Pacemaker	☐	☐
16. Taking blood thinner	☐	☐
17. Abnormal bleeding	☐	☐
18. High cholesterol	☐	☐
19. Anemia	☐	☐
20. Blood disease	☐	☐
21. AIDS or HIV	☐	☐
22. Arthritis	☐	☐
23. Autoimmune Disease	☐	☐
24. Rheumatoid arthritis	☐	☐
25. Lupus	☐	☐
26. Bloody cough	☐	☐
27. Asthma	☐	☐
28. Bronchitis	☐	☐
29. Emphysema or Lung Disease	☐	☐
30. Sinus trouble	☐	☐
31. Tuberculosis	☐	☐
32. Cancer	☐	☐
33. Chemotherapy	☐	☐
34. Radiation treatment	☐	☐
35. Bruise easily	☐	☐
36. Chronic pain	☐	☐
37. Diabetes Type I or II	☐	☐
38. Depression	☐	☐
39. Gastrointestinal Disease	☐	☐
40. Eating disorder	☐	☐
41. Reflux/persistent heartburn/GERD	☐	☐
42. Ulcers	☐	☐
43. Thyroid problems	☐	☐
44. Stroke	☐	☐
45. Glaucoma	☐	☐
46. Hepatitis, or liver disease Type A, B C	☐	☐
47. Epilepsy or seizures	☐	☐
48. Fainting spells	☐	☐
49. Sleep apnea	☐	☐
50. Kidney problems	☐	☐
51. Night sweats	☐	☐
52. Osteoporosis	☐	☐
53. Persistent swollen glands in neck	☐	☐
54. Alcoholism	☐	☐
55. Excessive headaches /migraines	☐	☐
56. Excessive urination	☐	☐
57. Severe or rapid weight loss	☐	☐
58. Sexually transmitted Disease	☐	☐
59. Chemical dependency	☐	☐
60. Steroid treatment (ex. Prednisone)	☐	☐
61. Facial cosmetic surgery	☐	☐
62. Anxiety	☐	☐
63. Mental health disorders. Specify:	☐	☐
64. Recurrent infections. Type of infection:	☐	☐
65. Neurological disorders. If yes, specify:	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ Yes ☐ No

Have you been to the emergency room in the last year? ☐ Yes ☐ No

If so, why? _____

Do you have any disease, condition, or problem not listed on this form? ☐ Yes ☐ No

Please explain: _____

AUTHORIZATION

I hereby certify that I have read and understand the previous information and that it is accurate and true. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health. If I ever have a change in my health, I will inform the office before my next appointment without fail.

I have not made any errors or omissions to my medical and dental history.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate. I also authorize a dental cleaning if that is recommended.

I understand that I may need to be prescribed medication to treat my dental condition and anesthetics may need to be administered. I understand that antibiotics, analgesics, anesthetics and other medications commonly used in dentistry can cause allergic reactions, temporary or permanent numbness, and/or anaphylactic shock.

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, payors, and/or healthcare practitioners. If I have insurance, I authorize the payment from my insurance carrier to submit 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. I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services on my behalf or on behalf of my dependents (if any).

Signature of Patient/Legal Guardian	Date	Relationship

Signature of Dentist	Date

FOR COMPLETION BY DENTIST ONLY