CONFIDENTIAL DENTAL / MEDICAL HISTORY

TenderCare® • DENTAL OFFICES •

Thank you for filling out this form completely. It will enable our office to be more effective in meeting your needs. The better we communicate, the better we can serve you. If you have a question at any time, please ask us. We will be glad to assist you.

Name _____ Today's Date_____-_____-_____

1. DENTAL HISTORY

Previous Dentist Name_____

_____

Previous Dentist Phone #(_____) _____ Last approximate visit date _____

What was done? _____

Date of last cleaning_____ Frequency of cleaning _____

Date of last full mouth dental x-rays (10+ films)_____

Why have you come to the dentist today? _____

_____

How do you rate your current dental health? ☐ Good ☐ Fair ☐ Poor

Do you like the appearance of your teeth? ☐ Yes ☐ No What would you change?_____

Would you like to discuss options to improve your smile? _____

Do you use floss? ☐ Yes ☐ No How often? _____

How often do you brush? _____

Type of bristles on your tooth brush ☐ Hard ☐ Medium ☐ Soft

Do you ever get cold sores or fever blisters? ☐ Y ☐ N How often? _____

Do you ever get canker sores? ☐ Y ☐ N How often? _____

☐ Y ☐ N Have you lost any teeth? If Yes, why? _____

☐ Y ☐ N Do you think you have cavities or gum disease? _____

☐ Y ☐ N Are your teeth sensitive to heat, cold, or anything else? _____

☐ Y ☐ N Do you smoke or use tobacco in any form? How much/often? _____

☐ Y ☐ N Have you ever had Orthodontic treatment? (tooth straightening) _____

☐ Y ☐ N Do you ever brux or grind your teeth? Describe: _____

☐ Y ☐ N Do you ever awaken with a headache? How often: _____

☐ Y ☐ N Do you ever have clicking, popping, or discomfort in the jaw joints (TMJ/TMD)? Describe: _____

☐ Y ☐ N Do you need to be premedicated before dental treatment? Explain: _____

☐ Y ☐ N Are you interested in using laughing gas (Nitrous Oxide) for your dental visits? (note: There is an additional fee for this service and is not a covered benefit under most insurance plans)

☐ Y ☐ N Do you feel nervous about having dental treatment? Explain:_____

☐ Y ☐ N Have you ever had a bad experience in a dental office? Describe _____

_____

☐ Y ☐ N Have you had difficulty following an extraction, or other dental treatment? Describe:_____

CONFIDENTIAL DENTAL / MEDICAL HISTORY (Continued)

2. MEDICAL HISTORY

Do you have a personal physician? Yes ☐ No ☐

Physician's Name _____ Physician's phone # (_____) _____

Approximate date of last physical _____

How do you rate your current physical health? ☐ Good ☐ Fair ☐ Poor

☐ Y ☐ N Are you under a doctor's care now? Please explain: _____

_____

☐ Y ☐ N Have you been hospitalized in the last 3 years? Why and When? _____

_____

☐ Y ☐ N Are you taking any prescription medication or substance? Please list each one: _____

medication _____ for _____

medication _____ for _____

medication _____ for _____

☐ Y ☐ N Do you use recreational or street drugs? _____

☐ Y ☐ N Have you ever taken Phen-Phen also known as Redux or Pandimin?

If so, when _____

Please check if you have had any of the following:

☐ Chest Pain	☐ Blood Disorder	☐ Alzheimer's Disease	☐ Chemotherapy/Radiation
☐ Heart Trouble	☐ Anemia	☐ Drug/Alcohol Addiction	☐ Artificial Joint/Hip
☐ Heart Murmur	☐ AIDS (HIV)	☐ Nervous Condition	☐ Implants
☐ Rheumatic Fever	☐ Hypoglycemia	☐ Herpes	☐ Lupus
☐ Congenital Heart Lesions	☐ Lung Disease	☐ Diabetes	☐ Arthritis/Gout
☐ Mitral Valve Prolapse	☐ Fainting or Dizziness	☐ Kidney Trouble	☐ Rheumatism
☐ Heart Pacemaker	☐ Asthma	☐ Dry Mouth	☐ Glaucoma
☐ Heart Surgery	☐ Hay Fever	☐ Tuberculosis	☐ Cortisone Medicine
☐ Artificial Heart Valve	☐ Sinus Trouble	☐ Hepatitis	☐ Thyroid Disease
☐ High Blood Pressure S _____D_____	☐ Stroke	☐ Epilepsy or Seizures	
☐ Low Blood Pressure Date_____	☐ Mental Disorder	☐ Cancer	

☐ Y ☐ N Have you ever had any other serious illnesses not checked above?

Describe: _____

☐ Y ☐ N Do you wish to talk with the Doctor privately about any problem?

_____

Are you allergic to any of the following?

☐ Y ☐ N Aspirin	☐ Y ☐ N Dental Anesthetics	☐ Y ☐ N Latex	☐ Y ☐ N Sulfa Drugs
☐ Y ☐ N Barbiturates	☐ Y ☐ N Erythromycin	☐ Y ☐ N Penicillin	☐ Y ☐ N Tetracycline
☐ Y ☐ N Codeine	☐ Y ☐ N Jewelry	☐ Y ☐ N Sedatives	☐ Y ☐ N Other

Please list additional drugs that cause allergic reaction _____

3. FOR WOMEN

☐ Y ☐ N Are you taking birth control pills?

☐ Y ☐ N Are you taking estrogen replacement therapy?

☐ Y ☐ N ☐ Unsure Are you pregnant? Week #_____

☐ Y ☐ N Are you nursing?

4. FOR CHILDREN

☐ Y ☐ N Are child's immunizations current?

Does / Did the child have any of the following habits?

☐ Y ☐ N Lip sucking/biting ☐ Y ☐ N Thumb/Finger sucking

☐ Y ☐ N Nail biting ☐ Y ☐ N Nursing/Bottle habits

5. TREATMENT AUTHORIZATION

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest of Confidence and it is my responsibility to inform the office of any changes in my medical status. I authorize TenderCare Dental to administer medication and perform diagnostic and therapeutic procedures as may be necessary for proper dental care.

_____ _____ _____

Patient Signature (Parent/Guardian) Date Doctor Reviewing Patient History Date

MEDICAL UPDATES - FOR OFFICE USE ONLY

I have read my Medical History dated_____and confirm that it adequately states past and present medical conditions.

DATE	CHANGES IN HEALTH	PATIENT'S SIGNATURE	REVIEWED BY
_____	☐ None	_____	Dr. _____
_____	☐ None	_____	Dr. _____
_____	☐ None	_____	Dr. _____
_____	☐ None	_____	Dr. _____