Complete Health Medical & Dental History Form

AKRON SMILE
Complete Health Dentistry

Although in Dentistry we primarily treat the mouth and all of its structures, the oral cavity is connected to the rest of the body and acts as the gateway to many of its organ systems. Health problems that you may have or medications that you may be taking could have an important interrelationship with the Dentistry you will receive. Therefore, it is important that you answer all of the pertinent questions. Thank you.

Name: _____ Date: _____ DOB: _____

Who may we thank for referring you? _____

Name and location of your physician: _____

Reason for today's visit: _____

PHONE Home _____ Cell _____

Social Security # _____ DOB: _____

Home address _____

E-mail address _____

Employer Name _____ Occupation _____

Emergency Contact _____ Emergency Phone _____

** Person responsible for the account is a [ ] Parent [ ] Guardian Name* _____

Personal Health

How would you rate your current health? [ ] Excellent [ ] Good [ ] Fair [ ] Poor

Current Age: _____ Weight: _____ Height: _____ Ethnicity: _____

Date of last dental care and previous dentist: _____ / _____

Check (✓) if you have had problems with any of the following:

- Bad Breath
- Grinding Teeth
- Sensitivity to hot or cold
- Bleeding gums
- Loose teeth
- Broken or cracked fillings
- Missing teeth
- Clicking or popping jaw
- Sensitivity to sweets
- Sensitivity when biting
- Food collecting between teeth
- Sores or growths in your mouth
- Dry mouth
- Snoring / Sleep Apnea

Personal Medical History

Have you ever been hospitalized for illness? [ ] Yes [ ] No

_____

_____

For women: Are you pregnant? [ ] Yes [ ] No Due date? _____

Please indicate whether you have had any of the following medical problems (Include dates too when possible)

Aortic aneurysm [ ] _____

Brain aneurysm [ ] _____

Bleeding problems [ ] _____

Artificial joint or valve [ ] _____

Heart Disease [ ] _____

Stroke [ ] _____

High Cholesterol [ ] _____

High Blood Pressure [ ] _____

Atrial Fibrillation [ ] _____

Pacemaker [ ] _____

Heart Arrhythmia [ ] _____

Heart Valve Problem [ ] _____

Rheumatoid Arthritis [ ] _____

Lupus [ ] _____

Psoriasis [ ] _____

Kidney disease [ ] _____

Pancreatic Disease [ ] _____

Diabetes [ ] _____

Cancer [ ] _____

Leukemia [ ] _____

Osteoporosis [ ] _____

AIDS / HIV [ ] _____

Hepatitis [ ] _____

Sjögren's Syndrome [ ] _____

Autoimmune disorder [ ] _____

Thyroid problems [ ] _____

Depression [ ] _____

Eating Disorders [ ] _____

Anxiety/Panic Attack [ ] _____

Migraine Headaches [ ] _____

Abnormal platelets [ ] _____

Chronic Heartburn [ ] _____

Alcoholism [ ] _____

Drug Use / Abuse [ ] _____

Medications: Please list all prescription and non-prescription medications, vitamins, home remedies, and herbs.

Medications/ Supplements	*Dose (mg, doses per day)*	*Start date*	*End date*
		/	
		/	
		/	
		/	
		/	
		/	

Allergies or reactions to medicines: _____

_____

_____

Surgical History

Please list all other operations with the dates when they occurred.

_____

_____

_____

_____

_____

Oral Health

Is there a specific dental problem that you currently have? _____

_____

How many times per day do you brush? _____ What type of toothbrush do you use? _____

Do you floss regularly? [ ] Yes [ ] No How often? _____

Does your oral health concern you? [ ] Yes [ ] No **If yes, why?** _____

Would you be interested in…

[ ] Yes [ ] No Straighter teeth with clear aligner therapy?
[ ] Yes [ ] No Better sleep at night?
[ ] Yes [ ] No Reducing snoring?
[ ] Yes [ ] No Whiter teeth?

Social history

Tobacco use

Cigarettes: [ ] *Never* [ ] *Quit:* date you quit smoking _____ [ ] *Current smoker* (packs per day) _____

Other tobacco (check all answers that apply): [ ] Pipe [ ] Cigar [ ] Chewing tobacco [ ] e-cigarettes

Number of years you've used this tobacco _____

Are you interested in quitting? [ ] Yes [ ] No Have you tried to quit in the past [ ] Yes [ ] No

Alcohol use

Do you drink alcohol? [ ] Yes [ ] No

If yes, how many drinks do you consume per week? _____

Does your alcohol consumption have you or others concerned about abuse or addiction? [ ] Yes [ ] No

Prescription Drug Use

Do you regularly use prescription opioids (pain-killers)? [ ] Yes [ ] No

Does your use of these medications have you or others concerned about abuse or addiction? [ ] Yes [ ] No

Exercise

Do you exercise regularly? [ ] Yes [ ] No

How often? _____

Do you have any limitations to your ability to exercise? Please explain: _____

Authorization

I authorize my insurance company to make payments directly to the dental office for benefits otherwise payable to me. I authorize the release of my records to third party payers, other healthcare professionals, or other entities as deemed necessary by this office. I authorize use of this signature for all insurance submissions.

I understant that I am responsible for all charges, whether or not they are covered by insurance, as well as any additional collection costs if this office determines they are necessary. I authorize this office to charge my credit card for any unpaid balances, including those charges not paid by insurance within 60 days. I understand that in certain circumstances, my credit report may be requested. I have reviewed the information on this form, and it is accurate to the best of my knowledge. I understand that check payments may be converted to automatic bank drafts.

I have received a copy of this office's Notice of Privacy Practices.

Signature _____ Date _____