GENERATIONS
DENTAL

MEDICAL HISTORY

PATIENT NAME:	DATE:

HOME PHONE:	MOBILE PHONE:
WORK PHONE:	EMAIL:

YOUR PREFERRED METHOD OF CONTACT: *(Check one)* ☐ HOME PHONE ☐ MOBILE PHONE ☐ WORK PHONE ☐ EMAIL

EMERGENCY CONTACT *(In case of emergency, whom should we contact?)*

NAME:	RELATIONSHIP:
MOBILE PHONE:	WORK PHONE:

MEDICAL HISTORY

Are you currently under the care of a physician for a specific condition? *(Check one)* ☐ YES ☐ NO	If yes, please explain:
Are you taking any over-the-counter or prescription medications? *(Check one)* ☐ YES ☐ NO	If yes, please list medications:

ALLERGY / SENSITIVITY INFORMATION

Do you have any allergies (including latex allergies) or other special health issues? ☐ YES ☐ NO	If yes, please explain:

Have you recently been hospitalized for any condition? *(Check one)* ☐ YES ☐ NO

Have you ever had any of the following medical conditions: *(Check all that apply)*

☐ Anemia / Radiation Treatment	☐ Asthma / COPD
☐ Cancer / Chemotherapy / Tumors	☐ Hepatitis
☐ Fainting / Dizziness / Epilepsy	☐ HIV / AIDS
☐ Heart Surgery / Heart Disease	☐ Diabetes
☐ Heart Abnormalities (heart murmur, mitral valve disease, artificial valves, etc.)	☐ Tobacco Use *(If yes, how often?)*:
	☐ Alcohol / Drug Abuse
☐ Liver Disease / Kidney Disease	☐ High or Low Blood Pressure
☐ Emphysema / Respiratory Problems / Tuberculosis	☐ Cold Sores / Herpes
☐ Mental or Nervous Disorders	☐ Artificial Joints / Arthritis
☐ Dementia / Alzheimer's Disease	☐ Glaucoma
☐ Headaches / Head Injuries	☐ Shingles
☐ Blood Disease / Excessive Bleeding / Blood Transfusions	☐ Thyroid Conditions
☐ Stomach Problems / Ulcers	☐ Venereal Disease

☐ Have you traveled to West Africa, or had contact with an aid worker in the last six months?

FOR WOMEN ONLY *(Please check)*

☐ Pregnant / Trying To Get Pregnant	☐ Nursing

☐ Taking Oral Contraceptives *(If yes, please explain)*:

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DENTAL HISTORY

How would you describe your current dental health? ☐ GOOD ☐ FAIR ☐ POOR

Are you currently in pain? ☐ YES ☐ NO

Are your teeth sensitive to heat or cold? ☐ YES ☐ NO

Have you ever had a serious or difficult problem associated with any previous dental work? ☐ YES ☐ NO

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ / TMD)? ☐ YES ☐ NO

Do your gums ever bleed? ☐ YES ☐ NO

Have you ever had periodontal disease? ☐ YES ☐ NO

How often do you floss? ☐ EVERY DAY ☐ EVERY OTHER DAY ☐ ONCE A WEEK ☐ I DON'T FLOSS
☐ OTHER *(If other please explain):*

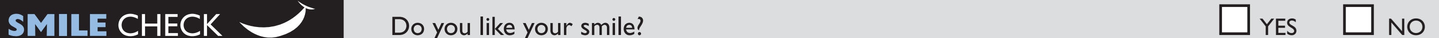
How many times a day do you brush? ☐ ONCE ☐ TWICE ☐ AFTER EVERY MEAL
☐ OTHER *(If other please explain):*

What type of bristles to you use? ☐ HARD ☐ MEDIUM ☐ SOFT

SMILE CHECK

Do you like your smile? ☐ YES ☐ NO

If you could change anything about your mouth, teeth or smile, what would it be? *(Please explain)*



Thank you for filling out this form completely. It will enable us to help you more effectively. Please ask us anytime you have questions or concerns, we are happy to help.

I certify that I have read and understand the previous information and that it 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 also understand that this information well be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform, with my consent, any necessary dental services I may need during diagnosis and treatment.

SIGNATURE of Patient or Responsible Party | **DATE** | **PRINT NAME** of Patient or Responsible Party