Palm Dental Group

www.palmdentalgroup.com
palmdentalgroup@live.com
7733 Palm St, Suite #107 • Lemon Grove, CA 91945 **(619)460-1991**

Dental History Form

Patient Name: _____ * _____ * _____ _____
Last First MI Preferred Name

What is the reason for your dental visit today?

When was your last visit to the dentist (if to a different office)?

What was done on your last dental visit (if to a different office)?

Prior Dentist's name, address, & phone number:

How frequently do you brush your teeth?

◯ 3 (+) a day ◯ Twice a day ◯ Once a day ◯ Weekly ◯ Seldom

How frequently do you floss your teeth?

◯ 1 (+) a day ◯ 2 - 6 weekly ◯ 1 - 6 monthly ◯ Seldom ◯ Never

Please mark any of the following to indicate Yes in response to the question:

- ☐ I clench or grind my teeth
- ☐ I like my smile
- ☐ I want my teeth whiter
- ☐ I have problems eating
- ☐ I have had orthodontics (ie. braces, Invisalign, etc)
- ☐ I want my teeth straighter
- ☐ My gums bleed while brushing and/or flossing
- ☐ I avoid brushing part of my mouth due to pain
- ☐ My gums feel tender or swollen
- ☐ My teeth are sensitive to cold or hot temperatures
- ☐ I have had a facial or jaw injury in the past
- ☐ I currently have dentures

If any of the previous questions are marked, please explain:

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

☐ **To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next detal appointment without fail.**

Authorization

I hereby 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 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, payors, 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:

Response Date: ____/____/_____

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Medical History Form

Patient Name: _____ * _____ * _____

Last First MI Preferred Name

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in fairly good health? ◯ Yes ◯ No

Within the past year, have there been any changes in your general health? ◯ Yes ◯ No

Your Primary Care Physician's name, address, & phone number:

_____

_____

_____

_____

What is the date (or approximate date) of your last medical exam?

_____

_____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No

If yes, please specify type of operation and date

_____

_____

_____

Have you ever had any complications following dental treatment? ◯ Yes ◯ No

Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates? ◯ Yes ◯ No

Do you use tobacco (smoking or chewing) or vape? ◯ Yes ◯ No

WOMEN ONLY: Are you...

☐ Pregnant/ trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to the following?

☐ Aspirin ☐ Ibuprofen ☐ Sulfa Drugs ☐ Penicillin ☐ Codeine ☐ Latex ☐ Metal

☐ Acrylic ☐ Local Anesthetics ☐ Other medications

Do you use controlled substances? ◯ Yes ◯ No

Do you have, or have had, any of the following?

- [ ] Allergies
- [ ] Anemia
- [ ] Arthritis
- [ ] Artificial Joints
- [ ] Asthma
- [ ] Blood Disease
- [ ] Cancer
- [ ] Codeine Allergy
- [ ] Diabetes
- [ ] Dizziness
- [ ] Epilepsy
- [ ] Excessive Bleeding
- [ ] Fainting
- [ ] Glaucoma
- [ ] Growths
- [ ] Hay Fever
- [ ] Head Injuries
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Hepatitis C
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] HIV
- [ ] Jaundice
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Major Operation
- [ ] Mental Disorders
- [ ] Nervous Disorders
- [ ] Pacemaker
- [ ] Paranoid
- [ ] Penicillin Allergy
- [ ] Pregnancy
- [ ] Premedicated
- [ ] Radiation Treatment
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] SEIZURE DISORDER
- [ ] Sinus Problems
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Ulcers
- [ ] Venereal Disease

Do you have any other health issues not listed? ◯ Yes ◯ No

☐ **If yes, please specify:**

Please list all medications, pills, or drugs you are currently taking:

What is the reason for your dental visit today?

In case of an emergency please contact: _____

Emergency contact phone #: _____

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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. 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.

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Signature of patient, parent, or guardian:

Signature _____ **Date** _____

Relationship to Patient:

Response Date: ____/____/_____