Wheaton cosmetic dentistry

Patient Name _____ Date of Birth: _____

MEDICAL HISTORY FORM

Reason for Visit _____ Last Dental exam: _____

Primary Physician_____Phone #_____ Last Physical exam:_____

Please check all that apply AND that you have experienced in the past:

Bleeding while brushing/ flossing
Pain in any of your teeth
Teeth sensitive to hot/cold
Mouth sores/ lumps
Head injury
Neck Injury
Jaw Injury
Diagnosed with gum periodontal disease
Treatment for periodontal disease
Require antibiotics before treatment
Prolonged bleeding after an extraction
Difficulty Chewing
Orthodontics
Received oral hygiene instructions on gum/ teeth care
Biting of lips/cheeks
Clench or grind teeth
Difficulty opening/ closing your mouth
Pain (joint, ear, side or face)
Clicking in jaw
Dentures/Partials Date_____

Have you ever had or currently any of the following (please check all that apply)**:**

HIV/AIDS
Alcohol/Drug Abuse
Anemia
Arthritis
Artificial Joints
Asthma/ Hay Fever
Epilepsy
Blood Disease
Blood Clots
BPPV-Vertigo
Cancer
Chemo Therapy
Chest Pain
Cold Sores
Cortisone Therapy
Diabetes
Dizziness
Parkinson
Excessive Bleeding
Fainting
Glaucoma
Head Injuries
Heart Disease /Defect
Heart Murmur
Heart Attack
Heart Surgery
Hepatitis/Jaundice
High Blood Pressure
Hypoglycemia
Joint Replacement
Kidney Disease
Liver Disease
Low Blood Pressure
Lyme Disease
Mental Disorder
Mitral Valve Prolapse
Nervous Disorder
Osteoporosis
Pacemaker
Pregnant Currently?____
Psychiatric Treatment
Radiation Therapy
Rheumatic fever
Rheumatism
Respiratory Problems
Sinus Problems
Stomach Problems
Stroke
Sickle Cell
Sinus Drip
Tonsillitis
Tuberculosis
Thyroid Problems
Tumor Ulcers
Ulcer/ Gerd
Venereal Disease
OTHER _____

Please list any **Allergies** i.e. (Food, Drugs, Latex, and Local Anesthetic)

_____

Are you taking Aspirin daily? YES NO
Are you under medical treatment? YES NO
Do you use tobacco? YES NO
IF PREGNANT, Are you nursing? YES NO
Do you use controlled Substances? YES NO
Have you ever been hospitalized for any operation or serious illness? YES NO
If YES, Please explain_____

Please list all Current Medications:

_____

Authorization & Release

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by Dr. SumeetBeri and his staff to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform Dr. Beri. I authorize my insurance company to pay Dr. Beri all insurance benefits otherwise payable to me for services rendered. I authorize use of this signature on all insurance submissions. I authorize Dr. Beri to release all information necessary to secure the payment if benefits. I understand that I am fully responsible for all charges whether covered or denied by my insurance company. Since at each visit Treatment Plans are presented and the care to be provided is explained to me prior to treatment, I give Dr. Beri my consent to perform any needed dental treatment, Including the use of local anesthetic as needed.

Patient Signature: _____ Date: _____

(If patient is under the age of 18, Signature of parent/legal guardian required below)

Parent/Legal Guardian(**please print**): _____ **Signature**: _____

Doctor's Signature _____ Date: _____