W Banks Allen DMD

myersparkdentalpartners.com info@myersparkdentalpartners.com
Perry T Sowell Jr, DDS | 1000 Queens Road • Charlotte, NC 28207 (704)332-2532

Medical & Dental 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.

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

_____

_____

Are you currently taking any prescription or non-prescription medications?

_____

_____

_____

Do you have any allergies?

_____

_____

Please indicate if you have experienced any of the following:

- ☐ Anxiety
- ☐ Blood Thinner
- ☐ Diabetes
- ☐ Hayfever/allergies
- ☐ Hemophilia
- ☐ HIV
- ☐ MVP
- ☐ Radiation Treatment
- ☐ Stent placed
- ☐ Ulcers
- ☐ Arthritis
- ☐ Cancer
- ☐ Dizziness
- ☐ Hearing Impaired
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Pacemaker
- ☐ Respiratory Problems
- ☐ Stroke
- ☐ Venous stasis
- ☐ Artificial Joints
- ☐ Chemotherapy
- ☐ Excessive Bleeding
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Liver Disease
- ☐ Partial PreMed
- ☐ Seizures
- ☐ Thyroid Problems
- ☐ Asthma
- ☐ Cold sore/fvr blistr
- ☐ Fainting
- ☐ Heart Murmur
- ☐ High Cholesterol
- ☐ Low Blood Pressure
- ☐ Postural Orthostatic
- ☐ Sinus Problems
- ☐ Tumors

WOMEN ONLY: Are you pregnant? ◯ Yes ◯ No

If Yes, when is the due date? _____

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

- ☐ Have you ever had complications following dental treatment?
- ☐ Are you currently under the care of a physician due to a specific condition?
- ☐ Have you been hospitalized within the last 5 years due to a surgery or illness?
- ☐ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

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

_____

_____

Prior Dentist's name, address, phone number & reason for visit:

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:

☐ Do your gums bleed when you brush or floss?

☐ Do your teeth experience sensitivity to cold or hot temperatures?

☐ Are any of your teeth currently causing you pain?

☐ Do you grind your teeth (either consciously or during sleep)?

☐ Are any of your teeth loose, or are you concerned about any teeth loosening?

☐ Do you use tobacco (smoking or chewing)?

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

☐ **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: _____