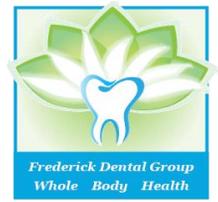


Today's Date: _____

Frederick Dental Group ~ Health History Update



Patient Information:

I prefer to be called: _____
(name)

Name: _____ DOB: ____/____/____

Address (NO PO BOX): _____

SSN: ____-____-____ Sex: M / F Height ____ Weight ____ lbs

Home Phone (____) _____ - _____ Cell Phone (____) _____ - _____

Email Address: _____

Single Married Divorced Separated Widowed

Employer: _____

Occupation: _____ Full Time or Part Time

Preferred Method of Contact:
We send Newsletters, appt reminders, and other
useful information

__ Home __ Cell __ Email

➤ Emergency Contact Number: _____

➤ Emergency Contact Name: _____



Has your Dental Insurance changed since your last visit? __ NO __ YES

(if yes, please provide us with your card so we may make a copy)

Please also provide your medical insurance cards so we may make a copy.

Primary Care Physician Name: _____

Primary Care Phone #: (____) _____ - _____ Date of Last Physical ____/____/____

List all surgeries to date (within the last year) : _____

Please list **ALL** medications you are taking: OTC, Prescriptions, supplements, etc.

I do **NOT** take any prescribed medications, over-the-counter medications, supplements or dietary supplements

❖ **Have you ever been advised to take a pre-medication before dental treatment? Y / N**

IF YES, please explain: _____

ALLERGIES: Circle All that apply

I have **NO** known allergies

Aspirin Iodine Sulfa Penicillin Latex Codeine

Tetracycline Erythromycin Local Anesthetic Other: _____

WOMEN:

Are you pregnant? Y / N

Due Date ____/____/____

Nursing? Y / N

Taking Birth Control? Y / N

Planning Pregnancy? Y / N

CHECK any of the following medical condition you have had:

NONE of the Following

<input type="checkbox"/>	Abnormal Bleeding	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	Respiratory Disease
<input type="checkbox"/>	AIDS/HIV	<input type="checkbox"/>	Circulatory Problems	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	Rheumatic fever
<input type="checkbox"/>	Alcohol Abuse	<input type="checkbox"/>	Colitis/IBS	<input type="checkbox"/>	Hepatitis A, B, C	<input type="checkbox"/>	Rheumatic Heart Disease
<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Congenital Heart Problems	<input type="checkbox"/>	O High / O Low Blood Pressure	<input type="checkbox"/>	Scarlet Fever
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Cortisone treatment	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	Angina	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	Shingles
<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	Difficulty Breathing	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	Sinus Problems
<input type="checkbox"/>	Artificial heart/valves	<input type="checkbox"/>	Drug Abuse	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	Sleep Apnea/snoring
<input type="checkbox"/>	Artificial joints (pins/screws)	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Nervous/Anxiety/Depression	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Pacemaker/Defib	<input type="checkbox"/>	Swelling feet/ankles
<input type="checkbox"/>	Back Problems	<input type="checkbox"/>	Fainting/Dizziness	<input type="checkbox"/>	Persistent cough	<input type="checkbox"/>	Swollen neck glands
<input type="checkbox"/>	Behavioral Problems	<input type="checkbox"/>	Fever Blisters	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	Thyroid Problems O Low / O High
<input type="checkbox"/>	Bleeding w/ extraction	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	Psychiatric care	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Blood transfusion	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Radiation Treatment	<input type="checkbox"/>	Ulcers/Tumors/growths
						<input type="checkbox"/>	Venereal Disease

Other (not listed above): _____

- Do you drink grapefruit juice? Yes No
- Do you wear contacts or glasses? Yes No

Do you use any of the following? Check all that apply: NONE of the Following

<input type="checkbox"/>	Cigarettes or Cigars	<input type="checkbox"/>	Smokeless tobacco	<input type="checkbox"/>	Marijuana
<input type="checkbox"/>	Vaping	<input type="checkbox"/>	Cocaine or derivatives		
<input type="checkbox"/>	Barbituates	<input type="checkbox"/>	Sleeping Pills	<input type="checkbox"/>	Opiates
<input type="checkbox"/>	Narcotic Pain Killers	<input type="checkbox"/>	Others: _____		

How many per day? _____ How many years? _____

- Please indicate your frequency of drug use and whether you inhale or inject: _____
- How many alcoholic drinks do you consume daily? _____

Do you have FAMILY history of any of the following? NONE of the Following

<input type="checkbox"/>	Stroke	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Alzheimer's
<input type="checkbox"/>	Gastro Issues	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	Heart Disease

Are you experiencing any of the following conditions?

Bleeding Gums	Grinding Teeth	Mouth Pain	Broken Denture	Jaw / Facial Pain
Swollen Gums	Lost/Loose Teeth	Sensitivity	Broken Teeth	Decay/Cavities
Lost Fillings	Bad Breath	Missing Teeth		

Would you like information about a Free Consult for any of the following services?

[Y] [N] Botox/Fillers

[Y] [N] Veneers/Cosmetics

[Y] [N] Whitening

[Y] [N] Dentures

[Y] [N] Implants

How often do you brush your teeth a day? 0 1 2 3

What type of toothbrush do you use? Manual Electric* Battery Powered* * _____ (Brand)

Is your manual brush bristle: Soft Medium Hard

How many times do you floss each day? 0 1 2 3+

How many sodas, tea, coffee, Gatorade, etc. do you consume a day? 1-2 3-4 5-7 7+

Is there anything we can do to make your visit more comfortable?

Multiple screenings will take place during your visits here at our office such as:

- Risk Assessment- Evaluation of your dental and medical history, and blood pressure.
- Oral Cancer Screening -Occlusal Screening -Airway Screening
- Restorative Screening- Checking completed dentistry and health of the teeth
- Periodontal Screening- Examine the health of your gums and risk of bone loss
- Complimentary WiFi is available for your use throughout the office. Please feel free to bring your wireless internet device with you each visit.
- Blankets are available to keep you warm and relaxed during each visit
- Memory foam neck pillows are available as well as eye masks.

HIPPA RELEASE:

I authorize the release of information including diagnosis, records, examination rendered to me and claims information. The information may be released to:

1. _____ Relationship: _____
2. _____ Relationship: _____

I do **NOT** authorize Frederick Dental Group to release information on my behalf

I attest that the above information I have provided is accurate and true to the best of my knowledge. I have answered all of the questions honestly and completely. I understand the doctor is basing his/her treatment and medications administered based on this information provided.

Signature

_____/_____/_____
Date