POPPER DENTAL

MEDICAL - DENTAL HISTORY

Patient's Name_____ Date_____/_____/_____

The following information is essential for this office to provide dental care in a manner that is compatible with your general health. Your cooperation in providing accurate information is necessary to meet your dental needs safely.

INCORRECT INFORMATION CAN BE DANGEROUS TO YOUR HEALTH

Street Address_____ Home #_____

City_____ State_____ Zip_____ Cell #_____

Email _____ Pharmacy + Ph #_____

SS#_____-_____-_____ D.O.B._____/_____/_____ Marital Status S M D W Spouse's Name _____

Guardian (if minor)_____ Address/Phone# _____

Person Responsible_____ Billing Address _____

Occupation_____ Employer Name & Phone # _____

Emergency Notification (Name & Phone # nearest relative) _____

****Referred by_____

Medical History

Name of Physician_____ Phone #_____

Date of last Visit_____ Reason for last visit_____

Are you currently under the care of a physician, if so for what reason?_____

Are you currently taking any medication or have you in the last 2 years? For what condition? _____

Have you ever had a major operation? Please describe _____

Have you ever injured your head or neck? Please describe _____

Are you currently taking Bisphosphonates/Osteoporosis drugs?_____

Do you have any allergies to any drugs or material? _____

Are you on a Special Diet? _____ WOMEN: Are you pregnant now? _____ Taking Birth Control? _____

Circle if you have or previously had any of the following: Smoker? Yes No Height_____ Weight_____

☐ Heart Failure	☐ Stroke	☐ Radiation Treatment	☐ Drug Addiction	☐ Heart Disease/Attack	☐ Diabetes
☐ Chemotherapy	☐ Hemophilia	☐ Angina Pectoris	☐ Low/High Blood Pressure	☐ Glaucoma	☐ Ulcers
☐ Cancer	☐ Leukemia	☐ Venereal Disease	☐ Pain in Jaw/Joints	☐ Syphilis,Gonorrhea	☐ Anemia
☐ Arthritis	☐ Heart Murmur	☐ Heart Lesions	☐ Artificial Heart Valve	☐ Sinus Trouble	☐ Cough
☐ Thyroid Disease	☐ Tuberculosis	☐ Cortisone Medication	☐ Epilepsy or Seizures	☐ Osteoporosis	☐ HIV/AIDS
☐ Scarlet fever	☐ Bruise Easily	☐ Liver Disease/Jaundice	☐ Fainting or Dizzy Spells	☐ Blood Thinners/Aspirin	☐ Snoring
☐ Rheumatism	☐ Hepatitis A B C	☐ Psychiatric treatment	☐ Heart Pacemaker	☐ Kidney Trouble	☐ Cold Sore
☐ Nervousness	☐ Allergies/Hives	☐ Sickle Cell Disease	☐ Heart Surgery/Stent/Bypass	☐ Artificial Joint	☐ Asthma
☐ Emphysema	☐ Rheumatic Fever	☐ Genital Herpes	☐ Blood Transfusion	☐ Sleep Apnea	☐ Hay Fever

Medical History Review & Significant Findings:

_____

_____

_____

POPPER DENTAL

Dental History

1. Date of your late Dental Visit?_____ Reason for visit? _____
2. Ever had an allergic reaction while at the dentist? _____
3. Any other complications during dental treatment? _____
4. Do your gums bleed when brushing or eating? _____
5. Have your teeth shifted or become loose? _____
6. Have you ever been under the care of a Periodontist or had an dental implant? _____
7. Are any of your teeth sensitive to heat, cold or pressure? _____
8. Do you grind your teeth or clench your jaw during the day or night? _____
9. Do you have pain or clicking in the jaw joint around your ear? _____
10. Are there any sores or growths in your mouth? _____
11. Do any of your teeth ache? _____

NOTE: A change in your health status should be reported to the office at the earliest possible time

To the best of my knowledge, the foregoing questions have been answered accurately.

Permission To Release Health Information

I grant the right to the dentist to release health information obtained by me, and information about my dental treatment to third party payers, and/or other health providers.

Person completing this form: Signature_____ Date_____

Print Name_____

Submit

Dental History Review & Significant Findings:

_____

_____

_____

_____

_____

Dr's Signature: _____ Date_____