Patient Dental/ Medical History

(Confidential)

LEVISON DENTAL

Reviewed by/ Date _____

BP_____

Dental History

1. Reason for today's visit (circle): Routine Emergency Consultation
   Explain:_____
2. Is there something about your smile that you would like to change? Y/N
   Explain:_____
3. Do you have aching, painful, or sensitive teeth? Y/N
4. Do your gums bleed or are tender while brushing or flossing? Y/N
5. Do you have pain/clicking/popping in your jaws? Y/N
6. Do you have frequent headaches? Y/N
7. Are you concerned with bad breath? Y/N
8. Have you ever had an injury to you head, neck, or jaws? Y/N
9. Do you clench or grind your teeth? Y/N
10. Do you play contact sports? Y/N
11. Have you used teeth whitening products? Y/N
12. Have you had serious trouble associated with past dental work? Y/N
13. Previous Dentist:_____Ph#_____
14. Date of last dental treatment and/or exam:_____
15. Do you have any uncompleted dental treatment that you are aware of? Y/N
    If yes, please list:_____

Medical History

1. Physicians Name_____Ph#_____
2. How would you rate your health? 1-10 (worst to best) _____
3. Are you under medical treatment now? Y/N
   If yes, for what:_____
4. Please list all medications/herbs/supplements you are taking:

   Drug Reason

   _____
   _____
   _____

   (attach list if necessary)
5. Have you ever been hospitalized for any surgical operation or serious illness? Y/N
6. Do you require antibiotics prior to dental treatment? Y/N
   If yes, name of drug_____
7. Do you have allergies or sensitivity to any drugs, foods, metals, materials, etc.? Y/N
   If yes, list:_____
8. Has a doctor warned you to avoid specific medication? Y/N
   If yes list:_____
9. Do you use alcohol? Y/N
10. Do you use illegal/street drugs? Y/N
11. Do you use tobacco products now? Y/N
    If yes, type:_____frequency:_____
12. Did you use tobacco products in the past? Y/N
    If yes, date you quit:_____
13. Women Only:
    Are you (circle)? Pregnant Nursing Taking Oral Contraceptives
14. Do you presently have or have you had in the past:

High/ Low blood pressure	Y/N
Heart Disease	Y/N
Stroke/ TIA	Y/N
Angina (Chest Pain)	Y/N
Pacemaker	Y/N
Cardiac Transplant	Y/N
Prosthetic heart valve	Y/N
History of infective endocarditis	Y/N
Congenital Heart Disease	Y/N
Prosthetic Joint	Y/N
AIDS/ HIV+	Y/N
Tuberculosis	Y/N
Anemia	Y/N
Hemophilia/ Excessive bleeding	Y/N
Blood disease	Y/N
Glaucoma	Y/N
Immunosupression	Y/N
Asthma	Y/N
Emphysema/ Breathing problems	Y/N
Sinus Infection	Y/N
Diabetes	Y/N
Stomach problems/ Ulcers	Y/N
Eating disorders	Y/N
Taken Bisphosphonates (ie Fosamax)	Y/N
Taken Redux or Fen-Phen	Y/N
Liver Disease	Y/N
Hepatitis A B C D	Y/N
Epilepsy/ Seizure	Y/N
Kidney Disease/ Dialysis	Y/N
Autoimmune disorder	Y/N
Cancer/ Tumors	Y/N
Radiation/ Chemotherapy	Y/N

Other not listed:_____

Thank you very much of providing us with the most accurate history possible. A thorough and accurate history is important in allowing us to treat you in the safest manner possible.

Authorization

I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize Levison Dental Group PC to release any medical or dental information rendered to me or my dependents to third party payors (ie: insurance company) and/or other health care providers. I further authorize that my insurance benefits be paid directly to Levison Dental Group PC.

X_____ **Date**_____

Patient signature