Hedrick Family Dentistry

hedrickfamilydentistry.com info@hedrickfamilydentistry.com

1807 Overlake Drive Suite A • Conyers, GA 30013-1765 (770)922-3131

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.

E-mail address:
(in the future we will be able to e-mail you appointment reminders)

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Within the past year, have there been any changes in your general health? ◯ Yes ◯ No

Your Primary Care Physician's name, phone number.

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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?
- ☐ Do you use tobacco (smoking or chewing)?
- ☐ Are you currently taking or have you ever taken medication for Osteoporosis?

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

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WOMEN ONLY: Are you pregnant? ◯ Yes ◯ No

If yes, what is your due date? ____________________

Please indicate if you have experienced any of the following:

☐ AIDS/HIV	☐ Anemia	☐ Anti-coagulants	☐ Arthritis
☐ Artificial Joints	☐ Artificial Valve	☐ Aspergers Syndrom	☐ Aspirin
☐ Asthma	☐ Autism	☐ Blind	☐ Blood Transfusions
☐ Cancer	☐ Cerebral Palsy	☐ Depression/Anxiety	☐ Diabetes
☐ Drug Allergies	☐ Emphysema	☐ Epilepsy	☐ HIV
☐ Head Injuries	☐ Heart Disease	☐ Hepatitis	☐ High Blood Pressure
☐ Kidney Disease	☐ Latex Allergy	☐ Liver Disease	☐ MRSA
☐ MVP	☐ Mental Disorders	☐ Pacemaker	☐ Past IV Bisphosphonate usage
☐ Physical Limitations	☐ Pre Med	☐ Prostate Cancer	☐ Radiation/Chemo Tx
☐ Respiratory Problems	☐ Rheumatic Fever	☐ Stent	☐ Stroke
☐ Surgical Tape	☐ Thyroid Condition	☐ Tobacco	☐ Tuberculosis
☐ Ulcers	☐ Venereal Disease	☐ Viral Herpes	☐ xOther

Explanation to any selected boxes above

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Please list all drug allergies.

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Please list all prescription and non-perscription medications you are currently taking.

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Please list all prior surgeries.

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Are there any other health issues we should be aware of?

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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 currently have any dental implants, dentures, or partials?

If you could change anything about your mouth, teeth, or smile, what would it be?

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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:

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☐ **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 dental appointment without fail.**

Response Date: __________