# Silverlake Family & Cosmetic Dentistry
## Medical/Dental History Form

Patients Last Name:_____First:_____M.I.___Sex: ☐ male ☐ female
SSN Last Four # _____ Date of Birth:_____ Age:_____
Patients Address:_____City:_____State:_____Zip:_____
Cell Phone #:_____Home Phone:_____Email: _____
Patient is: ☐single ☐ married ☐ widowed ☐separated ☐ divorced
Patient Employed by:_____Occupation:_____
Employer Address:_____City:_____State:_____Zip:_____
Whom may we thank for referring you?_____
Notify in case of emergency:_____ Home Phone:_____
Cell Phone:_____Business Phone:_____
Email:_____

## Insurance

**Primary**

Insured's Name:_____
Insured's Relation to Patient:_____
Insured's Employer:_____
Insured's SSN:_____
Insured's Date of Birth:_____
Insurance Co. Name: _____
Insurance Co. Email:_____
Insurance Co. Phone #:_____
Group # (plan or policy #):_____
Subscriber # _____
Other dependants under plan:_____

**Additional**

Insured's Name:_____
Insured's Relation to Patient:_____
Insured's Employer:_____
Insured's SSN: _____
Insured's Date of Birth:_____
Insurance Co. Name:_____
Insurance Co. Email:_____
Insurance Co. Phone #:_____
Group # (plan or Policy #):_____
Subscriber # _____
Other dependants under plan:_____

## Dental History

What would you like us to do today?_____
Former Dentist _____Address _____
Dentist Email_____Phone_____
Last Dental Visit:_____Date of Last Dental X-Ray:_____

Has the patient had or have any of the following: (Please Select)

| | | | |
|---|---|---|---|
| ☐ Bad Breath | ☐ Food Collection between teeth | ☐ Periodontal Treatment | ☐ Sensitivity to Sweets |
| ☐ Bleeding Gums | ☐ Grinding or Clenching teeth | ☐ Sensitivity to Cold | ☐ Sensitivity when biting |
| ☐ Clicking or popping jaw | ☐ Loose teeth or broken fillings | ☐ Sensitivity to Hot | ☐ Sores or growths in mouth |

How often do you brush?_____Floss:_____
How do you feel about the appearance of your teeth?_____
Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐yes ☐no
Other information about your dental health or previous treatment_____

## Medical History

Has the patient had any of the following: (Please check all that apply)

| | | | | | |
|---|---|---|---|---|---|
| ☐ Hepatitis | ☐ Diabetes | ☐ Kidney Problems | ☐ Sinus Problems | ☐ Immune Disorder | ☐ Lip or Tongue Biting |
| ☐ Frequent Headaches | ☐ Heart Disease | ☐ Bleeding Gums | ☐ Arthritis | ☐ Speech Impairment | ☐ Nail Biting |
| ☐ Cerebral Palsy | ☐ Epilepsy | ☐ Liver Disease | ☐ Convulsions/Seizures | ☐ Tonsils/Adenoids | ☐ Tuberculosis |
| ☐ Rheumatic Fever | ☐ Excessive Bleeding | ☐ Cold Sores/Fever Blisters | ☐ Throat Infections | ☐ Mouth Breathing | ☐ Hemophilia |
| ☐ Frequent Colds | ☐ Thyroid Problems | ☐ Dizziness or Fainting | ☐ Grinding of Teeth | ☐ Thumb/Finger Sucking | ☐ Difficult Breathing |
| ☐ Latex Sensitivity | ☐ Artificial Joints | ☐ AIDS/HIV | ☐ Radiation Therapy | ☐ Chemotherapy | ☐ Other |

Please Explain:_____
Physician's Name:_____Phone_____
Date of last visit_____Have you had any serious illnesses or operations? ☐ yes ☑ no
If yes, describe_____
Are you currently under physician care? ☐ yes ☐ no If yes, describe_____
Have you ever had a blood transfusion? ☐ yes ☑ no If yes, give approximate dates_____
Women: Are you pregnant ☐ yes ☑ no Nursing? ☐ yes ☐ no Taking birth control pills? ☐ yes ☑ no

Have you ever taken Fen-Phen/ Redux? ☐ yes ☐ no

Has you had or have any of the following: (Please Select)

| | | | |
|---|---|---|---|
| ☐ AIDS/HIV Positive | ☐ Persistent Cough | ☐ Jaw Pain | ☐ Shingles |
| ☐ Anaphylaxis | ☐ Cough up Blood | ☐ Kidney Disease/Malfunction | ☐ Shortness of Breath |
| ☐ Anemia | ☐ Diabetes | ☐ Liver Disease | ☐ Skin Rash |
| ☐ Arthritis, Rheumatism | ☐ Epilepsy | ☐ Periodontal Treatment | ☐ Spina Bifida |
| ☐ Artificial Heart Valves | ☐ Fainting | ☐ Material Allergies (latex, etc) | ☐ Stroke |
| ☐ Artificial Joints | ☐ Food Allergies | ☐ Mitral Valve prolapse | ☐ Surgical implant |
| ☐ Asthma | ☐ Glaucoma | ☐ Nervous problems | ☐ Swelling of Feet/ Ankles |
| ☐ Atopic (allergy prone) | ☐ Headaches | ☐ Pacemaker/ Heart surgery | ☐ Thyroid Disease / Malfunction |
| ☐ Back Problems | ☐ Heart Murmur | ☐ Psychiatric Care | ☐ Tobacco habit |
| ☐ Cancer | ☐ Heart Problems | ☐ Rapid Weight gain/loss | ☐ Tonsillitis |
| ☐ Chemical Dependency | ☐ Hemophilia/Abnormal Bleeding | ☐ Radiation Treatment | ☐ Tuberculosis |
| ☐ Chemotherapy | ☐ Herpes | ☐ Respiratory Disease | ☐ Ulcer/colitis |
| ☐ Circulatory Problems | ☐ Hepatitis | ☐ Sensitivity to Cold | ☐ Venereal Disease |
| ☐ Cortisone treatments | ☐ High Blood Pressure | ☐ Rheumatic/Scarlet Fever | |

Please list any medications you are currently taking _____

_____

Do you have any drug allergies? If yes, please list all _____

_____

## Authorization

I certify that I have answered the above questions to the best of my ability. I will not hold Dr. Marvin Rodrigue, Silverlake Family & Cosmetic Dentistry. or any member of its staff responsible for any errors or omissions that I may have made in the completion of this form. I will take full financial responsibility for any and all records taken, and will pay the cost of x-rays and other records taken at the time of consultation and/or diagnosis.

_____ _____

Signature of Patient (Parent or Guardian if Patient is a Minor) Date

Print Submit