Accent Dental LLC

2002 S. ROUSE ST • PITTSBURG, KS 66762 (620)231-2871

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 and in a way that watches out for your overall health and well-being.

Would you consider yourself to be in fairly good health? ◯ Yes ◯ No

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

What is the date (or approximate date) of your last medical exam?

_____

_____

Your Primary Care Physician's name, address, & phone number:

_____

_____

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?

☐ Have you been hospitalized within the last 5 years due to a surgery or illness?

☐ Are you currently taking any prescription or non-prescription medications?

☐ Do you use tobacco (smoking or chewing)?

☐ Do you require the use of corrective lenses (contacts or glasses)?

☐ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

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

_____

_____

WOMEN ONLY: Are you pregnant? ◯ Yes ◯ No

If Yes, when is the due date? _____

Please indicate if you have experienced any of the following:

- ☐ -
- ☐ AGRANULOCYTOSIS
- ☐ Amoxicillin
- ☐ Auto-Immune Disorder
- ☐ BREAST CANCER
- ☐ CARPAL TUNNEL SYNDRO
- ☐ CONGESTIVE HEART FAI
- ☐ Cancer
- ☐ Chronic back pain
- ☐ DEFIBRILLATOR
- ☐ DOWN SYNDROME
- ☐ END STAGE RENAL DISE
- ☐ GUTTATE PSORIASIS
- ☐ HEART VALVE DAMAGE
- ☐ HYPERTHYROID
- ☐ Hepatitis
- ☐ Hypothyroidism
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ MULTIPLE SCLEROSIS
- ☐ NARCOLEPSY
- ☐ Other
- ☐ PROMETHAZINE
- ☐ Peripheral Neroupath
- ☐ Pregnant
- ☐ SARCOIDOSIS
- ☐ SPINAL STENOSIS
- ☐ Seizures
- ☐ TUBULO-INTERSTITBAL
- ☐ V-FIB
- ☐ anasef
- ☐ brest reduction
- ☐ degenerative disc di
- ☐ edema
- ☐ heart trouble
- ☐ knee replacement
- ☐ motrin
- ☐ oxygen
- ☐ phentanol
- ☐ tremor
- ☐ A-FIB
- ☐ AIDS
- ☐ Anemia
- ☐ BELL'S PALSY
- ☐ Blood Disease
- ☐ CATARAC SURGERY
- ☐ CONVULSIONS
- ☐ Cervical cancer
- ☐ Crohn's Disease
- ☐ DEMENTIA
- ☐ DYSTONIA
- ☐ Epilepsy/Convulsions
- ☐ HALDOL
- ☐ HEART VALVE REPLACE
- ☐ HYPOTENSION
- ☐ Hepatitis A
- ☐ INTELLECTUAL DISABIL
- ☐ LEUKEMIA
- ☐ MALAISE
- ☐ MYALGIA
- ☐ NEUTROPENIA
- ☐ PANCYTOPENIA
- ☐ PSYCHOTIC FEATURES
- ☐ Planter facitious
- ☐ RESTLESS LEGG
- ☐ SCHIZOPHRENIA
- ☐ STAPHYLOCOCCUS
- ☐ Sick Sinus Syndrome
- ☐ Thyroid disease
- ☐ VENTRAL HERNIA
- ☐ angina pectoris
- ☐ cardiac arrhythmia
- ☐ dental anxiety
- ☐ emphysema
- ☐ hernia
- ☐ limited opening
- ☐ murmur
- ☐ panic attacks
- ☐ phenytoin
- ☐ vitamin deficiency
- ☐ ACUTE KIDNEY FAILURE
- ☐ ALZHEIMERS
- ☐ Artificial Joints
- ☐ BIPOLAR
- ☐ Brain aneurysm
- ☐ CIRRHOSIS
- ☐ COPD
- ☐ Chemotherapy
- ☐ Cystic Fibrosis
- ☐ DIGENERATIVE SPINE
- ☐ Diabetes
- ☐ Excessive Bleeding
- ☐ HEART ATTACK
- ☐ HEREDITARY ANGOEDEMA
- ☐ Head Injuries
- ☐ High Blood Pressure
- ☐ KIDNEY TRANSPLANT
- ☐ LUPUS
- ☐ MALNUTRITION
- ☐ Memory Loss
- ☐ Non-Verbal
- ☐ PARATHYROID
- ☐ Pacemaker
- ☐ Polycystic ovary syn
- ☐ Radiation Treatment
- ☐ SEPSIS
- ☐ STD
- ☐ Stroke
- ☐ Tuberculosis
- ☐ WHEELCHAIR BOUND
- ☐ bextra
- ☐ constipation
- ☐ diazepam
- ☐ gall bladder surg
- ☐ hypokalemia
- ☐ metoclopramide
- ☐ neuromuscular dysfun
- ☐ paroxetine
- ☐ pneumonia
- ☐ ADRENAL INSUFFICENCY
- ☐ ANGINA
- ☐ Autistic
- ☐ BLOOD CLOT
- ☐ Bypass
- ☐ COGNITIVE COMMUNICAT
- ☐ CORONARY ARTERY STEN
- ☐ Chronic Pain
- ☐ DEAF
- ☐ DOES NOT READ LIPS
- ☐ ENCEPHALOPATHY
- ☐ GBM
- ☐ HEART SURGERY
- ☐ HIV
- ☐ Heart Disease
- ☐ High Cholestrol
- ☐ KNEE SCOPE
- ☐ Left Bundle Block
- ☐ MITRAL VALVE PROLAP
- ☐ Mental Disorders
- ☐ OVERACTIVE BLADDER
- ☐ PORT PLACED
- ☐ Parkinson's Disease
- ☐ Pre-diabetic
- ☐ Rheumatic Fever
- ☐ SLEEP APNEA/C-PAP
- ☐ STENTS
- ☐ TRIGEMINAL NEURALGIA
- ☐ UNSPECIFIED OSTEOART
- ☐ ZINC
- ☐ bladder stones
- ☐ cytoxan
- ☐ drug induced subacut
- ☐ gastro-esophageal re
- ☐ insomnia
- ☐ mician
- ☐ no known allergies
- ☐ partial hip replacem
- ☐ smokes

Do you have any other health issues or allergies?

What is the reason for your dental visit today?

When was your last visit to the dentist (if to a different office)?

What was done on your last dental visit (if to a different office)?

Prior Dentist's name, address, & phone number:

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 any of the previous questions are marked, please explain:

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

☐ **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 detal appointment without fail.**

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:

Response Date: _____