Sherrill Dental Arts
CREATING HEALTHY SMILES

# PATIENT MEDICAL HISTORY FORM

**Patient Information**

Name: _____ Birthdate: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Preferred Contact (circle): Home Cell Okay to Text Confirmations? Yes No

Email (for online bill pay if preferred): _____

Sex: ❑ M ❑F Marital Status: ❑ Minor ❑ Married ❑ Single ❑ Widowed

Employer or School: _____

Spouse, partner or parent name: _____

Emergency Contact: _____ Phone: _____

How did you learn about our practice/whom may we thank for referring you? _____

Who is the responsible party for your account/payment:_____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

**Dental Insurance** *(we do not accept insurance payment as payment in full at Sherrill Dental Arts)*

Insurance Company: _____ Phone: _____

Subscribers last 4 of SSID: _____ Group #: _____ ID#: _____

Policy Holder name: _____ Policy Holder DOB: _____

*Secondary Insurance?*

Insurance Company: _____ Phone: _____

Subscribers last 4 of SSID: _____ Group #: _____ ID#: _____

Policy Holder name: _____ Policy Holder DOB: _____

**Dental History**

Reason for today's visit: _____

Date of last dental visit: _____ Date of last x-rays: _____

Check any of the following concerns you may have:

| | | |
|---|---|---|
| ❑ Bad Breath | ❑ Loose teeth or broken fillings | ❑ Invisalign needs |
| ❑ Bleeding gums | ❑ Prolonged bleeding after exo's | ❑ Esthetic smile concerns |
| ❑ Clicking or popping of jaw | ❑ Sensitivity to: hot cold sweets | ❑ Mouth Sores |
| ❑ Food collection between teeth | ❑ Sensitivity when biting | ❑ Grinding of teeth |

How often do you floss: ❑ 1X daily ❑ 2X Daily ❑ A few times a week ❑ Not often

Is there anything you would like to improve about your smile? _____

| ALLERGIES AND CURRENT MEDICATIONS | |
|---|---|
| Drug allergies: ❑ No ❑ Yes To what? | Please list any allergies below |

1._____
2._____
3. _____
4. _____
5. _____

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

| MEDICATION Name of drug | Dose (include strength & number of pills per day) I How long have you been taking this? |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |
| 6. | |
| 7. | |
| 8. | |

**PAST AND CURRENT MEDICAL HISTORY**

Do you now or have you ever had:

❑ Diabetes
❑ High blood pressure
❑ High cholesterol
❑ Hypothyroidism
❑ Goiter
❑ Cancer (type) _____
❑ Leukemia
❑ Psoriasis
❑ Angina
❑ Heart problems
❑ Heart Valve Replacement
❑ Cardiac Stent
❑ Heart murmur
❑ Pneumonia
❑ Pulmonary embolism
❑ Asthma
❑ Emphysema
❑ Stroke
❑ Epilepsy (seizures)
❑ Cataracts
❑ Kidney disease
❑ Kidney stones
❑ Hip Replacement
❑ Knee Replacement
❑ Crohn's disease
❑ Colitis
❑ Anemia
❑ Jaundice
❑ Hepatitis
❑ Stomach or peptic ulcer
❑ Rheumatic fever
❑ Tuberculosis
❑ HIV/AIDS
❑ Infective Endocarditis
❑ ABX Pre-med required
❑ Pregnant

Other medical conditions (please list):

**Preferred Pharmacy** _____

*Name* *Office* *Phone Number*

**Primary Care** _____

**Cardiologist** _____

**Orthopedic Surgeon** _____

**Other** _____