Bristol Family Dental, PC

815 Pine St. • Bristol, CT 06010--4448 (860)589-2794

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.

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

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

_____

_____

Please indicate if you have experienced any of the following:

- ☐ Allergy- Anesthetic
- ☐ Allergy- Aspirin
- ☐ Allergy- Codeine
- ☐ Allergy- Foods
- ☐ Allergy- NSAIDs
- ☐ Allergy- Other
- ☐ Allergy- Pen/Amox
- ☐ Allergy- Sulfa Drugs
- ☐ Angina
- ☐ Artifical Heartvalve
- ☐ Asthma
- ☐ Blood Thinner Use
- ☐ Cancer
- ☐ Cold sores (Herpes)
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Glaucoma
- ☐ Heart attack
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Health Care
- ☐ Oral Contraceptives
- ☐ Pacemaker
- ☐ Reflux/GERD
- ☐ Snoring
- ☐ Stroke
- ☐ Surgery history
- ☐ Vertigo

Do you have any other health issues or allergies?

_____

_____

_____

Please list any medications you are currently taking, one medication per line:

_____

_____

_____

Have you been hospitalized within the last 5 years due to surgery or illness? ◯ Yes ◯ No

If yes, please explain: _____

Have you had an orthopedic total joint replacement? ◯ Yes ◯ No

Have you taken, or are scheduled to take, antiresorptive agent (ie. Fosamax, Actonel, Boniva, Reclast, Prolia, Aredia, Zometa, XGEVA)?
◯ Yes ◯ No

Has any medical provider recommended you premedicate with antibiotics prior to dental appointments? ◯ Yes ◯ No

Do you use tobacco (smoking or chewing or vaping)? ◯ Yes ◯ No

Do you use marijuana? Medicinal or Recreational? ◯ Yes ◯ No

WOMEN ONLY: Are you pregnant? ◯ Yes ◯ No

If Yes, when is the due date? _____

Are you breastfeeding? ◯ Yes ◯ No

Dental History

What is the reason for your dental visit today?

_____

_____

When was your last dental visit and what was done? _____

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

How frequently do you brush your teeth?

◯ 2(+) a day ◯ Daily ◯ Weekly ◯ Seldom

How frequently do you floss your teeth?

◯ Daily ◯ 3-4 times per week ◯ Occasionally ◯ 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 or biting?

☐ Are any of your teeth currently causing you pain?

☐ Do you clench or 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?

☐ Have you ever had complications following dental treatment?

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

_____

_____

☐ **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. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.**

Signature of patient, parent, or guardian:

Signature _____ **Date** _____

Relationship to Patient:

_____

_____

Provider Signature:

Signature _____ **Date** _____

_____

Response Date: _____