



Welcome to our office! It is our goal to provide you with an exceptional experience at every visit. We take pride in our friendly environment and quality dental care. Please complete the following information. Thank you!

Medical History

Name of Primary Care Physician

Phone Number of Physician

Date of Last Exam

Name of Specialty Provider

Phone Number of Specialist

Date of Last Exam

Preferred Pharmacy

By signing below, the patient consents for the office to retrieve their medical history. (This enables our doctors to observe allergies, possible interaction with other medications, etc. when prescribing medications to you.)

How would you rate your overall health? Excellent Good Fair Poor

Have you ever been hospitalized?*

Yes No

If yes, please explain:

Are you subject to frequent headaches?*

Yes No

If yes, please explain:

Are you currently pregnant?*

Yes No

Are you currently breastfeeding?*

Yes No

If pregnant, when is your due date?

Do you currently smoke, vape, or use smokeless tobacco?*

Smoke Vape Smokeless Tobacco

Not Applicable

Do you currently drink alcohol?*

Yes No

If yes, please select the appropriate response.

Less than 1 drink per month

1-3 drinks per month

1-3 drinks per week

1-3 drinks per day

If yes, how many years have you smoked, vaped and/or used smokeless tobacco?

If yes, how often do you smoke, vape, or use smokeless tobacco?

Allergies (Check all that apply)*

- | | | | |
|--|---------------------------------------|--|---|
| <input type="checkbox"/> Acetaminophen | <input type="checkbox"/> Doxycycline | <input type="checkbox"/> Iodine | <input type="checkbox"/> Metals |
| <input type="checkbox"/> Amoxicillin | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Keflex | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Fluoride | <input type="checkbox"/> Latex | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Ceclor | <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Local Anesthesia with Epinephrine | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Codeine | | | <input type="checkbox"/> Not Applicable |

Please explain any unlisted allergies:

Medical Conditions (Check any that you have at the present or have had in the past.)*

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> ACE Inhibitor | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> HPV | <input type="checkbox"/> Sinus Issues |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Jaundice | <input type="checkbox"/> STD |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fainting | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> STI |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stomach Issues |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout | <input type="checkbox"/> Lumps in Mouth | <input type="checkbox"/> Stomach Ulcers |
| <input type="checkbox"/> Autoimmune Disease | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Back Problems | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mitral-Valve Prolapse | <input type="checkbox"/> Thyroid Issues |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> TMJ |
| <input type="checkbox"/> Cancer - Existing | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer - Melanoma | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Cancer - Treated | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Cholesterol | <input type="checkbox"/> High / Low Blood Pressure | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Not Applicable |
| <input type="checkbox"/> Depression | | | |

Please explain any unlisted medical conditions. (Use the back of this page if more space is needed.)

Active Medications (Check all that apply)*

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Birth control | <input type="checkbox"/> Dietary Supplements | <input type="checkbox"/> Fosamax | <input type="checkbox"/> Premedication |
| <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> Erectile Dysfunction Medication | <input type="checkbox"/> Osteoporosis Medication | <input type="checkbox"/> Weight Control |
| | | | <input type="checkbox"/> Not Applicable |

List any current medications and / or medications taken within the last two years.

Describe any current medical treatment, impending surgery, or other treatment.

Dental Information

How would you rate the condition of your mouth? *

- Excellent Good Fair Poor

How fearful of the dentist are you? *

- Not Fearful
 Some Fear
 Very Fearful
 Require Sedation

Date of Most Recent Dental Exam

What is your immediate concern? (Use the back of this page if more space is needed.)

Dental History (Check all that apply) *

- Had an unfavorable dental experience or complications
 Had trouble getting numb or reactions to local anesthetic
 Had any teeth removed
 Had/have braces or orthodontic treatment
 Had cavities within the past 3 years

- Had deep cleanings or periodontal treatment
 Had root canal treatment
 You wear or have worn a bite appliance
 You have a dental implant(s)
 You have denture or partial dentures
 Not applicable

Current Dental Concerns (Check all that apply) *

- Any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth
 Noticed Grooves, notches or holes on your teeth, chipped teeth, or cracked filling(s)
 Food gets caught between any teeth
 You are noticing a dry mouth
 Gums bleed when brushing or flossing
 Noticed an unpleasant taste or odor in your mouth
 Noticed any lump/bump or discoloration on the tongue, cheeks or roof/floor of the mouth

- Gum recession
 Noticed loose or mobile teeth
 You have problems with your jaw joint or problems chewing
 Your teeth crowding or developing spaces
 Have you ever been disappointed with the appearance/function of previous dental work?
 You clench/grind your teeth

Is there anything about the appearance of your teeth that you would like to change?

Patient Information

Please input the patient's information below.

If you are completing this form on behalf of the patient, please also complete the "Legal Guardian" section on page 6.

| | | | |
|----------------------|----------------------|----------------------|--------------------------|
| First Name * | Last Name * | MI | Patient's Preferred Name |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |

| | | |
|----------------------|------------------------|---|
| Date of Birth * | Social Security Number | Gender * |
| <input type="text"/> | <input type="text"/> | <input type="checkbox"/> Female <input type="checkbox"/> Male |

Family Status *

Married Single Child Divorced Widowed Other _____

| | | |
|-------------------------|-------------------------|----------------------|
| Wireless Phone Number * | Home / Secondary Number | E-Mail Address * |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |

Mailing Address *

| | | |
|----------------------|----------------------|----------------------|
| City * | State * | Zip Code * |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |

| | | |
|--------------------------|----------------------------------|-----------------------|
| Emergency Contact Name * | Emergency Contact Phone Number * | Relation to Patient * |
| <input type="text"/> | <input type="text"/> | <input type="text"/> |

Whom may we thank for referring you to our office?

If someone other than the patient is the legal guardian or responsible for payment, please complete.

Legal Guardian Information

| | | | |
|-----------------------|-------------------------|----------------------|----------------------|
| First Name | Last Name | MI | Preferred Name |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Date of Birth | Social Security Number | Relation to Patient | |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | |
| Wireless Phone Number | Home / Secondary Number | E-Mail Address | |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | |
| Mailing Address | | | |
| <input type="text"/> | | | |
| City | State | Zip Code | |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | |

Person Responsible for Payment Information

| | | | |
|-----------------------|-------------------------|----------------------|----------------------|
| First Name | Last Name | MI | Preferred Name |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| Date of Birth | Social Security Number | Relation to Patient | |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | |
| Wireless Phone Number | Home / Secondary Number | E-Mail Address | |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | |
| Mailing Address | | | |
| <input type="text"/> | | | |
| City | State | Zip Code | |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | |

Acknowledgement

By checking this box, I acknowledge that the above information is correct. I understand that it is my responsibility to inform Keelan Dental of any changes to this information

Today's Date*

Signature*