Sorenson Dental

14688 Everton Ave N | Suite 104 • Hugo, MN 55038 (651)204-0201

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.

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?
- ☐ Do you use tobacco (smoking or chewing)?
- ☐ Drink alcohol?
- ☐ Use recreational drugs?
- ☐ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

_____

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 and clinic? _____

Please indicate if you have experienced any of the following:

- ☐ Chest pain
- ☐ Artificial Heart Valve/Pacemaker
- ☐ Swollen Ankles
- ☐ Late Sensitivity
- ☐ Hemophilia
- ☐ Congenital Heart Disease
- ☐ Cold Sores/blisters or any other oral lesions
- ☐ Thyroid Problems
- ☐ Blood Transfusion
- ☐ Bruise Easily
- ☐ Mitral Valve Prolapse
- ☐ Cortisone Medicine
- ☐ Emphysema
- ☐ Chemotherapy
- ☐ Psychiatric/Psychological Care

- ☐ *Pre-Med - Amox
- ☐ Allergy - Aspirin
- ☐ Allergy - Latex
- ☐ Anemia
- ☐ Blood Disease
- ☐ Epilepsy
- ☐ Head Injuries
- ☐ High Blood Pressure
- ☐ Liver Disease
- ☐ Pacemaker
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Venereal Disease
- ☐ *Pre-Med - Clind
- ☐ Allergy - Codeine
- ☐ Allergy - Other
- ☐ Arthritis
- ☐ Cancer
- ☐ Excessive Bleeding
- ☐ Heart Disease
- ☐ HIV
- ☐ Mental Disorders
- ☐ Pregnancy
- ☐ Rheumatism
- ☐ Tuberculosis
- ☐ *Pre-Med - Other
- ☐ Allergy - Erythro
- ☐ Allergy - Penicillin
- ☐ Artificial Joints
- ☐ Diabetes
- ☐ Fainting
- ☐ Heart Murmur
- ☐ Jaundice
- ☐ Nervous Disorders
- ☐ Radiation Treatment
- ☐ Sinus Problems
- ☐ Tumors
- ☐ Allergies
- ☐ Allergy - Hay Fever
- ☐ Allergy - Sulfa
- ☐ Asthma
- ☐ Dizziness
- ☐ Glaucoma
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Other
- ☐ Respiratory Problems
- ☐ Stomach Problems
- ☐ Ulcers

Do you have any other health issues or allergies? _____

Have you ever taken bone loss prevention drugs?

◯ Fosamax ◯ Actonel ◯ Boniva ◯ Other

WOMEN ONLY: Are you pregnant? Yes No If so, when is your due date?_____ Do you use prescription birth control? Yes No

Dental History

What is the reason for your dental visit today? _____

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

Prior Dentist's name and office: _____

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?

☐ Bite your lips or cheeks regularly?

☐ Mouth breathe while awake or asleep?

☐ Does food tend to become caught in between your teeth? If so, where _____

Have you ever had any of the following?

◯ Othrodontic treatment ◯ Oral Surgery ◯ Periodontal Treatment

◯ A bite plate or mouth guard ◯ A serious injury to the mouth or head

Have you experienced:

◯ Clicking or popping of the jaw ◯ Pain (joint, ear, side of face) ◯ Difficulty in opening or closing the mouth

◯ Difficulty chewing on either side of the mouth ◯ Headaches, neck aches or shoulder aches

Are you satisfied with the appearance of your teeth? ◯ Yes ◯ No

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 dental 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 _____ **Date** _____

Relationship to Patient: _____

Doctor Signature: _____ **Date:** ____/____/____

Response Date: ____/____/____