ROBERT M. SCHWAN, DMD
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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:

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WOMEN ONLY: Are you pregnant?

◯ Yes ◯ No

If Yes, when is the due date?

Please indicate if you have experienced any of the following:

☐ Alcohol/Drug Add.D.	☐ Allergic-Other	☐ Anemia
☐ Arthritis	☐ Artific.Jts/Valves	☐ Asthma
☐ Auto-Immune Disease	☐ BCP/Menopause	☐ BldThin:ASA/Coumadin
☐ Blood Dis./Transfus.	☐ Cancer/ChemoTx	☐ Chronic Pain
☐ Codeine Allergy	☐ Diabetes	☐ Dizziness/Fainting
☐ Drug Allergies	☐ Eating Disorder	☐ Epilepsy/Seizures
☐ Epinephrine Sensitiv	☐ Frequent Headaches	☐ Genetic Condition
☐ GERD	☐ Glaucoma	☐ Head/Spinal Injuries
☐ Heart Disease	☐ Hepatitis	☐ Herpes/Fever Blister
☐ High Blood Pressure	☐ HIV+/Aids	☐ Hrt Murmur/ProlapseV
☐ Hx Smoking/Tobacco C	☐ Kidney Disease	☐ Latex Allergy
☐ Liver Disease	☐ Low Blood Pressure	☐ Lymes Disease
☐ Metal Allergies	☐ Migraine Headaches	☐ MPD
☐ Nervous/Anxious	☐ Osteoarthritis	☐ Osteoporosis
☐ Other	☐ Pacemaker	☐ Penicillin Allergy
☐ Pregnancy	☐ PRE-MEDICATE	☐ Psych. Care/Depress.
☐ Radiation Treatment	☐ Radiation Treatment	☐ Respiratory Problems
☐ Rheum./Scarlet Fever	☐ Salicylate Allergy	☐ Sinus Problems
☐ Sleep Apnea	☐ Stomach/Bowel Dis.	☐ Stroke
☐ Thyroid Disease	☐ Tuberculosis	☐ Tumors/Growths

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☐ Ulcers ☐ Venereal Disease

Do you have any other health issues or allergies?

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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:

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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: