Montecito Dental Group: ❑Dr. Benedetto ❑Dr. Scarcello ❑Dr. Shepard

PATIENT HEALTH INFORMATION

DATE _____

NAME _____
LAST FIRST M/I

Primary reason for this dental appointment: ❑Examination ❑Emergency ❑Consultation ❑Cleaning ❑Whitening ❑Other_____

ORAL HEALTH INFORMATION

1. Any problems at this time? ❑Yes ❑No Describe _____
2. Are any of your teeth sensitive to hot, cold, biting pressure, or sweets? ❑Yes ❑No Describe _____
3. Do your gums bleed when your brush or floss? ❑Yes ❑No Describe _____
4. Have you ever had treatment for periodontal (gum) disease? ❑Yes ❑No Describe _____
5. Are there areas in your mouth you avoid chewing on? ❑Yes ❑No Describe _____
6. Have you had x-rays in the past year? ❑Yes ❑No Describe _____
7. Have you ever had orthodontic treatment (braces)? ❑Yes ❑No Describe _____
8. Do your jaw joints (TMJ) click, pop, or cause pain? ❑Yes ❑No Describe _____
9. Are you aware of any nighttime clenching or grinding of your teeth? ❑Yes ❑No Describe _____
10. Date and nature of last dental visit _____
11. Name and address of previous dentist that we may contact for records _____
12. Describe your homecare routine _____
13. Is there anything else you would like us to know about your dental health or your previous dental treatment?

MEDICAL HEALTH INFORMATION

1. Physician's Name _____ Date last seen_____
2. Are you under a physician's care now? ❑Yes ❑No Discuss reason_____
3. Any hospitalization in the past 5 years? ❑Yes ❑No
4. Have you had any serious illnesses or operations? ❑Yes ❑No (Include joint replacement surgery)
5. Are you taking any medications, pills or drugs? ❑Yes ❑No Please List _____
6. Are you allergic to any medication or substances? ❑Aspirin ❑Penicillin ❑Codeine ❑Novocain ❑Metals ❑Other_____
7. WOMEN (Please check) ❑Pregnant (Due date _____) ❑Nursing
8. Do you have, or have you (ever) had, any of the following? (please check and describe below):

Yes	No		Yes	No		Yes	No	
❑	❑	Rheumatic fever	❑	❑	Exposure to HIV virus	❑	❑	Epilepsy or seizures
❑	❑	Any heart problem?	❑	❑	Tuberculosis	❑	❑	Any other disease, condition, or problem treatment that you think the doctor should know about? _____
❑	❑	Antibiotic pre-medication	❑	❑	Other transmittable disease			
❑	❑	High blood pressure	❑	❑	Fainting or dizziness			
❑	❑	Malignancy	❑	❑	Stroke	❑	❑	Latex Allergy
❑	❑	Excessive bleeding	❑	❑	Diabetes	❑	❑	Phen Phen
❑	❑	Hepatitis	❑	❑	Psychiatric treatment	❑	❑	Osteoporosis Medication

9. Do you know of any reason why routine dental procedures might pose a risk to you, the dental staff, or other patients? ❑Yes ❑No
10. Is there anything important about your medical condition we have not asked? _____

Remarks _____

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medications change, I shall inform the dentist and staff at the next appointment without fail.

X_____ Date _____
Patient's Signature (Parent or Guardian)

MEDICAL INFORMATION UPDATES

Reviewed by _____ Date _____

I have read my MEDICAL HISTORY dated _____and confirm that it adequately states past and present conditions.

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	REVIEWED BY
_____	_____	NONE ❑	_____	_____
_____	_____	NONE ❑	_____	_____