WE SMILE DENTISTRY
DR. GIULIO SPAGNUOLO

MEDICAL HISTORY (ADULT)

Patient Name *
First Name Last Name

Date *
Month Day Year

Address *
Street Address
City
Postal / Zip Code

Gender *

Birth Date *
Month Day Year

Marital Status *

Home Phone Number *
Area Code Phone Number

Cell Phone Number *
Area Code Phone Number

Email Address *
example@example.com

Employer

Present Position

How Long Held

Work Phone Number
Area Code Phone Number

Do you have any insurance? *
Yes No

*
Self Other

The relationship to the patient

Name

Address
Street Address
City
Postal / Zip Code

Date of birth
Month Day Year

Insurance company name

Group/Plan Number

ID Number

Do you have secondary insurance? *
Yes No

The relationship to the patient

Name

Address

Street Address

City

Postal / Zip Code

Date of birth

Month Day Year

Insurance Company name

Group Number

Plan Number

In Case of Emergency Call

Name *

First Name Last Name

Phone Number *

Area Code Phone Number

Relationship *

I first learned about this dental office from *

- Internet
- School
- Other
- Work

Referred By

- Another Patient, Friend
- Another Patient, Relative
- Doctor/Staff Member
- Other

Name of Person Who Referred

DENTAL HISTORY

Have you been having any specific problems? *

- Yes
- No

Describe *

Last Dental Visit?

Purpose

Last Complete Exam

Has fear of discomfort kept you from regular visits? *

- Yes
- No

How do you describe your dental health? *

- Good
- Fair
- Poor

Describe *

Do you think you have

Decay *
◯ Yes ◯ No

Gum Disease *
◯ Yes ◯ No

Home Care

Brush *
◯ Yes ◯ No

Floss *
◯ Yes ◯ No

Water Jet *
◯ Yes ◯ No

Do your gums ever bleed? *
◯ Yes ◯ No

How Often?

Are you troubled with bad breath? *
◯ Yes ◯ No

Is there anything that you would like to change about your smile? *
◯ Yes ◯ No

What they would like to change? *

Have you had any unusual effects from previous dental treatment? *
◯ Yes ◯ No

Describe

MEDICAL HISTORY
(Confidential. Repeated every 5 year)

Date *
Month Day Year

MD's Name

Last Physical

Age

Are You Pregnant? *
◯ Yes ◯ No

Expected Due Date
Month Day Year

Are you a smoker *
◯ Yes ◯ No

If yes, how long have you been smoking, and how frequently? *

Are you under a doctor's care now? *
◯ Yes ◯ No

If so, for what reason? *

Are you taking any medications, pills, drugs? *
◯ Yes ◯ No

Please List

Do you have any medical conditions/concerns?

◯ Yes ◯ No

If your answer is 'Yes', check the relevant box/es and provide details.

- ☐ Heart problems
- ☐ Prosthetic Valves/Joints
- ☐ Low Blood Pressure
- ☐ Circulatory problems
- ☐ Excessive bleeding
- ☐ Anemia
- ☐ Rheumatic fever
- ☐ Birth Control Pill or Patch
- ☐ Measles
- ☐ HIV/AIDS
- ☐ High Blood Pressure
- ☐ Typhoid Fever
- ☐ Nervous problems
- ☐ Psychiatric Care
- ☐ Hospitalization
- ☐ Allergy to Anaesthetics
- ☐ Diabetes
- ☐ Mumps
- ☐ Malignancies
- ☐ Radiation treatment
- ☐ Asthma
- ☐ Stroke
- ☐ Ulcer
- ☐ Allergy to medicines/drugs
- ☐ Hepatitis
- ☐ Arthritis
- ☐ Venereal Disease
- ☐ Herpes
- ☐ Tuberculosis
- ☐ Sinus problems
- ☐ Tonsilitis
- ☐ Other

Provide details of Heart Problems *

Provide details of Measles *

Provide details of Diabetes *

Provide details of Hepatitis *

Provide details of Prosthetic Valves/Joints *

Provide details of HIV/AIDS *

Provide details of Mumps *

Provide details of Arthritis *

Provide details of Low Blood Pressure *

Provide details of High Blood Pressure *

Provide details of Malignancies *

Provide details of Venereal Disease *

Provide details of Circulatory problems Disease *

Provide details of Typhoid Fever *

Provide details of Radiation treatment *

Provide details of Herpes *

Provide details of Excessive bleeding *

Provide details of Nervous problems *

Provide details of Asthma *

Provide details of Tuberculosis *

Provide details of Anemia *

Provide details of Psychiatric Care *

Provide details of Stroke *

Provide details of Sinus problems *

Provide details of Rheumatic fever *

Provide details of Hospitalization *

Provide details of Ulcer *

Provide details of Tonsilitis *

Provide details of Birth Control Pill or Patch *

Provide details of Allergy to Anaesthetics *

Provide details of Allergy to medicines/drugs *

Medical Condition other than listed above:

Have you had any other serious illness? *

◯ Yes ◯ No

Explain *

Have you been hospitalized in the last 2 years? *

◯ Yes ◯ No

Why? *

Do you prefer Nitrous Oxide Sedation?

◯ Yes ◯ No

Do you wish to talk to the doctor about any problem not listed? *

◯ Yes ◯ No

Authorization: I hereby authorize the doctor and/or staff of this dental office to administer such medications and to perform such diagnostic and therapeutic procedures as may be necessary for proper dental care as agreed upon through consultation with me. The information which appears on these dental and medical histories is correct to the best of my knowledge.

Signature

Name *

First Name Last Name

Date *

Month Day Year