Sears Dental Works
Dr. Brent D. Sears DMD PA

Adult Medical and Dental History

Patient Name: _____ DOB: _____

Address: _____

Phone Number: _____ Home or Cell (circle)

Emergency Contact (Name/Phone #): _____

Responsible Party

Name: _____DOB:_____ SSN# _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____

Employer Name: _____

Primary Insurance

Primary Insurance Name: _____

Address: _____ Phone Number: _____

City, State, Zip _____

Name of Insured: _____ Relationship: _____

Insured's Social Security Number: _____ DOB: _____

ID Number: _____ Group Number: _____

Secondary Insurance

Secondary Insurance Name: _____

Address: _____ Phone Number: _____

City, State, Zip _____

Name of Insured: _____ Relationship: _____

Insured's Social Security Number: _____ DOB: _____

ID Number: _____ Group Number: _____

Medical History

1. Physician_____Address _____

2. When was your last physical examination? _____

3. Are you under the care of a physician? .....☐Yes ☐No

If yes, for what reason(s)?
_____

4. Are you presently taking any medications/drugs/pills/herbals/supplements? .....☐Yes ☐No

If yes, please list: _____

5. (Women) Is there a chance you are pregnant? .....☐Yes ☐No

If yes, anticipated due date?
_____

6. Do you take oral contraceptives? ..... ☐Yes ☐No

7. Are you allergic/sensitive to: ☐None ☐Codeine ☐Penicillin ☐Local Anesthetic ☐Latex ☐Pine Nuts ☐Dyes ☐Other: _____

8. Do you smoke, chew tobacco, or use E-cigarettes? ..... ☐Yes ☐No

If yes, please indicate which one(s), daily frequency, and how long? _____

9. Do you have Diabetes? ..... ☐Yes ☐No

If yes, please indicate: ☐Type 1 ☐Type 2 Last

10. Do you have, or have you ever had:

Abnormal blood pressure.....☐Yes ☐No	Anemia ..... ☐Yes ☐No
Arthritis..... ☐Yes ☐No	Artificial heart valve/stent/graft.....☐Yes ☐No
Artificial joint replacements ..... ☐Yes ☐No	Asthma ..... ☐Yes ☐No
Cancer .....☐Yes ☐No	Chemical dependency ..... ☐Yes ☐No
Chemotherapy/radiation .....☐Yes ☐No	Congenital heart defects ..... ☐Yes ☐No
Corticosteroid treatment ..... ☐Yes ☐No	Epilepsy/seizures .....☐Yes ☐No
Excessive or prolonged bleeding .... ☐Yes ☐No	Fainting spells ..... ☐Yes ☐No
Glaucoma .....☐Yes ☐No	Hearing impaired ..... ☐Yes ☐No
Heart murmur ..... ☐Yes ☐No	

HbA1c date and level: _____

Heart pacemaker .....☐Yes ☐No	Heart surgery ..... ☐Yes ☐No
Heart trouble .....☐Yes ☐No	Hepatitis (Type __) ..... ☐Yes ☐No
HIV positive/AIDS .....☐Yes ☐No	Jaundice .....☐Yes ☐No
Kidney trouble/Dialysis .....☐Yes ☐No	Leukemia .....☐Yes ☐No
Oral herpetic lesions ..... ☐Yes ☐No	Osteoporosis/treatment w/Bisphosphonates ☐Yes No
Psychiatric care ..... ☐Yes ☐No	Rheumatic fever .....☐Yes ☐No
Sexually transmitted disease .....☐Yes ☐No	Sinus trouble ..... ☐Yes ☐No
Stroke .....☐Yes ☐No	Thyroid problem .....☐Yes ☐No
Tuberculosis or Lung Disease .....☐Yes ☐No	Ulcers/GERD .....☐Yes ☐No

11. Do you take pre-medication for anything? .....☐Yes ☐No

If you pre-medicate, what for?

_____

12. Have you had any other serious illness, hospitalization or accident?.....☐Yes ☐No

If yes, please explain:

_____

Dental History

1. Former Dentist _____ Address_____

2. When did you last visit a dentist? _____When was your last cleaning? _____

X-rays taken? .....☐Yes ☐No

If yes, ☐Full Mouth Series ☐Bitewings ☐Panoramic

What was done at your last visit?

_____

Why did you leave that dentist? _____

Has any dental treatment been recommended to you that you have not had done?

_____

3. Are you aware of any dental problems ..... ☐Yes ☐No

If yes, please explain:

_____

4. Please rate the present condition of your mouth: ***Poor*** 1 2 3 4 5 6 7 8 9 10 ***Excellent***

5. Have you ever been treated for gum disease? .....☐Yes ☐No

If yes, what was done?

_____

6. Do you have well water? .....☐Yes ☐No

7. Is your water fluoridated? .....☐Yes ☐No

8. Are your teeth sensitive to: ☐Nothing ☐Sweet ☐Cold ☐Heat ☐Pressure

9. Please rate the appearance of your smile: ***Poor*** 1 2 3 4 5 6 7 8 9 10 ***Excellent***

10. Would you like a whiter smile? .....☐Yes ☐No

11. Would you like straighter teeth?..... ☐Yes ☐No

12. Have you had your teeth straightened/worn braces? ..... ☐Yes ☐No

13. Are you concerned with bad breath (malodor)? .....☐Yes ☐No

14. Are you concerned with snoring or sleep apnea? .....☐Yes ☐No

15. Are you concerned with grinding or clenching your teeth (bruxism)? ..... ☐Yes ☐No

16. Do you wear a bite guard? .....☐Yes ☐No

17.Are you aware of possible TMJ problems?(Does your jaw joint make noise, lock up, or create pain).....☐Yes ☐No

18. Are you interested in sleep/sedation dentistry? .....☐Yes ☐No

19. Is there anything else that would be valuable for your dentist to know to best care for you?

_____

☐ **I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.**

☐ **I authorize the release of any information concerning my (or my child's) healthcare, advice, and treatment to another dentist.**

☐ **I have accurately advised my dental care provider of my current health status and any dietary or herbal supplements, medications, and/or drugs (including recreational and over the counter) that I am taking or have taken in the last week.**

Patient Signature _____ Date _____

(Parent/Guardian)

Dentist Signature _____ Date _____