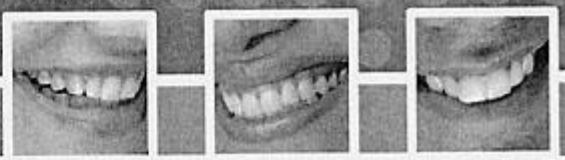
Garrison Family Dentistry
P.O. Box 369
Flat Rock NC 28731

(828)693-6555
dental@garrisondds.net
garrisonfamilydentistry.com



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)?
☐ Have you ever required Pre-medication prior to dental treatment?
☐ Have you ever had a reaction to any medication?
☐ 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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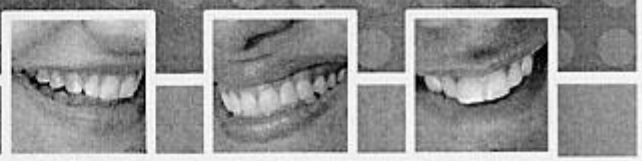

Please indicate if you have experienced any of the following:

- ☐ AIDS/HIV positive
- ☐ Allergies
- ☐ Alzheimers
- ☐ Anemia
- ☐ Angina
- ☐ Arterial Disease
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Aspirin Allergy
- ☐ Aspirin Daily
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Cephalexin Allergy
- ☐ Cerebral Palsy
- ☐ Codeine Allergy
- ☐ Coumadin
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Epinephrine Reaction
- ☐ Erythromycin allergy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Chloresterol
- ☐ Kidney Disease
- ☐ Latex allergy
- ☐ Liver Disease
- ☐ Lung Disease
- ☐ Lupus
- ☐ M.S.
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Other not-listed
- ☐ Pacemaker
- ☐ Parkinson Disease
- ☐ Penicillin Allergy
- ☐ Pregnancy
- ☐ Pre-Med necessary
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Sjogrens Syndrone
- ☐ Stomach Problems
- ☐ Stroke/T.I.A.
- ☐ Tetracycline Allergy
- ☐ Thyroid Disease
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Under Doctors Care

WOMEN ONLY: Are you pregnant?

◯ Yes ◯ No

If Yes, when is the due date?

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Do you have any other health issues or allergies?

Please list your medications: dosage and frequency.

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

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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?

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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: