WELCOME TO OUR PRACTICE

Michael S. Howl, D.D.S.

Medical/Dental History

PATIENT INFORMATION:

First Name: ______________________________ M.I.__________ Last Name: _______________________________

Address: _________________________________ City: ___________________ State: _________ Zip: ___________

Sex: ◯ Male ◯ Female DOB: __________________ Age: __________ SSN #: ______________________________

Home: _______________ Work: _______________ Cell: _____________Email: ____________________________

Employer: _____________________________________ Employer Phone #: ________________________________

Referred By: _________________________ Previous Dentist: ___________________ Contact #: ________________

Spouse Name: _____________________________________ Spouse Phone #: _______________________________

Spouse Employer: _____________________________________ Employer Phone #: __________________________

Preferred Pharmacy Name: ____________________________________ Pharmacy #: _________________________

Medical Doctor's Name: __________________________________ Doctor's # _______________________________

IN CASE OF AN EMERGENCY, PLEASE CONTACT: ____________________________ Phone #: ___________________

PRIMARY DENTAL INSURANCE INFORMATION:

Name of Insured: ______________________________________ Relationship to Patient: _____________ DOB: _________

Insurance Company Name: __________________________________ Insurance Phone #: ___________________________

Members ID#: ___________________________________ Members Group #: ____________________________________

Insurance Co. Address: _____________________________ City: _________________ State: _________ Zip: ____________

SECONDARY INSURANCE INFORMATION:

Name of Insured: _________________________________ Relationship to Patient: ________________ DOB: ___________

Insurance Company Name: ____________________________________ Insurance Phone #: _________________________

Members ID#: ____________________________________ Members Group #: ___________________________________

Insurance Co. Address: ____________________________ City: __________________ State: _________ Zip: ____________

MEDICAL HISTORY:

LIST OF MEDICATIONS YOU ARE CURRENTLY TAKING & FOR WHAT MEDICAL CONDITON:

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____

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Do you use tobacco? (i.e. cigarettes, pipe and/or vape) ◯ Y ◯ N If yes, complete the following:

How much? _______________ For how long? ____________________

Do you take aspirin daily? If yes, ___________mg or ◯ No Do you have a latex allergy? ◯ Y ◯ N

Do you take antibiotics routinely prior to dental care? Y or N, if Yes, what antibiotic: _________________________

List all medications you are allergic to: (i.e., Codeine, Aspirin, Penicillin, Ibuprofen

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Check any of the following conditions that you have had or have presently.

◯ Arthritis
◯ Artificial Joint Replacement
◯ Anemia
◯ Asthma
◯ AIDS
◯ Stroke
◯ Allergies
◯ Epilepsy or Seizures
◯ Diabetes
◯ Heart Disease or Attack
◯ Heart Murmur
◯ Heart Surgery
◯ Heart Pacemaker
◯ Mitral Valve Replacement

◯ Rheumatic or Scarlet Fever
◯ Lupus
◯ Multiple Sclerosis (MS)
◯ STD
◯ HIV
◯ Ulcers
◯ Liver Disease
◯ Cold Sores/Canker
◯ Tuberculosis (TB)
◯ Thyroid Disease
◯ Radiation Therapy
◯ Organ Transplant
◯ Pain in Jaw Joints

◯ Low Blood Pressure
◯ High Blood Pressure
◯ Stroke
◯ Shingles
◯ Fainting/Dizziness
◯ Memory Issues
◯ Chemotherapy
◯ Eating disorder
◯ Hep A (Infectious)
◯ Hep B (Serum)
◯ Hep C
◯ COPD
◯ Blood Thinners

◯ Cancer- Describe ____

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◯ Other condition not listed: ____

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CHECK:

Are you having pain or discomfort at this time? ◯ No ◯ Yes, if so where? _____________________________

Do you feel nervous about dental treatment? ◯ No ◯ Yes

Have you ever been treated for Periodontal Disease? ◯ No ◯ Yes, if so what year? ______________________

Do you grind your teeth? ◯ No ◯ Yes, If yes do you wear a Night Guard ____________________

Women:

Are you currently pregnant? ◯ No ◯ Yes

Are you taking Birth Control? ◯ No ◯ Yes

To the best of my knowledge, all of the preceding answers are true and correct. If I have any change in my health, or my medicine changes, I will inform the dentist at the next appointment.