JENNIFER GRANT FAMILY DENTISTRY
MEDICAL HISTORY UPDATE

Patient Last Name:	**Patient First Name:**
Address:	**Dental Insurance Provider:**
	Email:
	Cell Phone: **Home Phone:**

MEDICAL HISTORY	
Physician's name:	Name or address of clinic:
Physician's phone #:	Which pharmacy do you use?

SINCE YOUR LAST VISIT TO THE DENTIST		
Have you had any serious illnesses or operations?		If yes, describe:
Please provide approximate dates:		
Have you had abnormal bleeding associated with previous extractions or surgery?		
★ Have you had previous skin reactions to jewelry or know of any allergy to metal?		
Are you currently taking any medications?		If yes, please list them:
★ Allergies or reaction to any medications?		If yes, please list them:
Has there been a change in your general health?		If yes, please explain:
Women, are you pregnant?	If yes, due date:	Nursing: Using birth control pills?

PLEASE CHECK IF YOU HAVE/HAD							
AIDS or HIV +		Circulatory Problems		Osteoporosis		Scarlet Fever	
Anemia		Cold Sores/Fever Blisters		Jaw Pain/Clicking		Shortness of Breath	
Arthritis		Congenital Heart Lesions		Kidney Disease		Sickle Cell Disease	
Artificial Heart Valves		Diabetes		Liver Disease		Sinus Trouble	
Artificial Joints		Emphysema		Mitral Valve Prolapse		Sleeping Problems	
Asthma		Epilepsy		Nervous Problems		Snoring Problems	
Back Problems		Fainting		Pacemaker		Steroid Treatment	
Blood Disease		Glaucoma		Persistent Cough		Stroke	
Blood Transfusion		Headaches		Psychiatric Care		Swelling of Feet/Ankles	
Bruise Easily		Heart Murmur		Radiation to head/neck		Thyroid Problems	
Cancer		Hemophilia		Reaction to Medication		Tobacco Habit	
Chemical Dependency		Hepatitis		Respiratory disease		Tonsillitis	
Chemotherapy		High Blood Pressure		Rheumatic fever		Tuberculosis	
Do you have a disease, condition, or problem not listed that you think I should know?						Ulcers	
						Venereal Disease	

AUTHORIZATION
I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party and/or health practitioners.
_____ _____
Signature of Patient (or parent if patient is a minor) Date

SMILE ASSESSMENT	
Are you comfortable showing your teeth? YES or NO	Is cost or time holding you back from the perfect smile? YES or NO
Do you like the color of your teeth? YES or NO	
Are you familiar with the benefits of replacing missing teeth? YES or NO	Are your gums or teeth sensitive or receded? YES or NO