Adult Medical Form

Date:_____ Email:_____

Name (*first and last*):_____ D.O.B:_____ Sex:____

Address (*street*):_____

City, State, Zip:_____

Home Phone:_____ Work Phone:_____ Mobile:_____

Circle one: Married Single Divorced Widowed S.S.#_____

Occupation:_____ Employer:_____

Employer Address:_____ Phone:_____

General Dentist:_____ Phone:_____

Dental Insurance Carrier:_____

Emergency Contact:_____Phone:_____

Whom may we *thank* for referring you today?_____

Dental History

Reason for today's visit _____

Former Dentist _____City/State _____

Date of last dental visit _____Date of last dental X-rays _____

Place a circle "Yes" or "No" to indicate if you have had any of the following:

Bad Breath	Yes	No	Loose teeth or broken fillings	Yes	No
Bleeding Gums	Yes	No	Orthodontic treatment	Yes	No
Burning sensation on tongue	Yes	No	Mouth pain, brushing	Yes	No
Cigarette, pipe, or cigar smoking	Yes	No	Pain around ear	Yes	No
Clicking or popping jaw	Yes	No	Periodontal Treatment	Yes	No
Dry mouth	Yes	No	Sensitivity to cold	Yes	No
Food collection between the teeth	Yes	No	Sensitivity to heat	Yes	No
Grinding teeth	Yes	No	Sensitivity to sweets	Yes	No
Gums swollen or tender	Yes	No	Sensitivity when biting	Yes	No
Jaw pain or tiredness	Yes	No	Sores or growths in your mouth	Yes	No

Medications

Have you ever taken any of the following medications? FOSAMAX_____ BONIVA_____ ACTONEL_____

List any other medications you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy Name _____Phone (_____) _____

Are you taking any medications at this time	Yes	No
Are you under medical care	Yes	No
Have you had any unfavorable reaction(s) to dental/medical care	Yes	No
Any previous hospitalizations	Yes	No

Date of your last dental exam _____

Date of your last medical exam _____

If you answered Yes to any of these, please explain:

_____

_____

Allergies

Aspirin

Local Anesthetic

Barbiturates (Sleeping pills)

Penicillin Codeine

Sulfa

Iodine

Latex

Other _____

Women

Are you pregnant?

Yes No

Due date _____

Are you nursing?

Yes No

Taking birth control pills?

Yes No

Medical History

Do you have or had any of the following:

AIDS/HIV	Yes	No
Epilepsy	Yes	No
Respiratory Disease	Yes	No
Anemia	Yes	No
Fainting or dizziness	Yes	No
Rheumatic Fever	Yes	No
Arthritis, Rheumatism	Yes	No
Glaucoma	Yes	No
Scarlet Fever	Yes	No
Artificial Heart Valves	Yes	No
Headaches	Yes	No
Shortness of Breath	Yes	No
Artificial Joints	Yes	No
Heart Murmur	Yes	No
Sinus Trouble	Yes	No
Asthma	Yes	No
Heart Problems	Yes	No
Skin Rash	Yes	No
Back Problems	Yes	No
Hepatitis Type	Yes	No
Special Diet	Yes	No
Bleeding abnormally, with extractions or surgery	Yes	No
Herpes	Yes	No
Stroke	Yes	No
High Blood Pressure	Yes	No
Swollen Feet or Ankles	Yes	No
Blood Disease	Yes	No

Jaundice	Yes	No
Swollen Neck Glands	Yes	No
Cancer	Yes	No
Jaw Pain	Yes	No
Thyroid Problems	Yes	No
Chemical Dependency	Yes	No
Kidney Disease	Yes	No
Tonsillitis	Yes	No
Chemotherapy	Yes	No
Liver Disease	Yes	No
Tuberculosis	Yes	No
Circulatory Problems	Yes	No
Low Blood Pressure	Yes	No
Tumor or growth on head	Yes	No
Congenital Heart Lesions	Yes	No
Mitral Valve Prolapse or neck	Yes	No
Cortisone Treatments	Yes	No
Nervous Problems	Yes	No
Ulcer	Yes	No
Cough, persistent or bloody	Yes	No
Pacemaker	Yes	No
Venereal Disease	Yes	No
Diabetes	Yes	No
Psychiatric Care	Yes	No
Weight Loss, unexplained	Yes	No
Emphysema	Yes	No
Radiation Treatment	Yes	No

I hereby authorize Dr. Jacqueline Fulop-Goodling and/or her associates to render any services deemed necessary in my treatment.

Date:_____ Signature:_____

Dr. JacquieSmiles® Invisalign Expert & Zoom Specialist