



576 Kokopelli Blvd. Suite B • Fruita, Colorado 81521
(970) 858-4544 • www.andreolettidental.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:

Have you ever had complications following dental treatment?

Yes No

If Yes, please explain





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Are you currently under the care of a physician due to a specific condition?

Yes No

If Yes, please explain.

Have you been hospitalized recently for a surgery or illness (past 3 years)?

Yes No

If Yes, please explain

Are you currently taking any prescription or non-prescription medications?

Yes No

If Yes, please list.

WOMEN ONLY: Are you pregnant or trying to get pregnant?

Yes No

If Yes, when is the due date?

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Please indicate any of the following that apply to you:

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> *Pre-Med - Amox | <input type="checkbox"/> *Pre-Med - Amox | <input type="checkbox"/> *Pre-Med - Clind | <input type="checkbox"/> *Pre-Med - Other |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Allergy - Aspirin | <input type="checkbox"/> Allergy - Codeine | <input type="checkbox"/> Allergy - Erythro |
| <input type="checkbox"/> Allergy - Hay Fever | <input type="checkbox"/> Allergy - Latex | <input type="checkbox"/> Allergy - Other | <input type="checkbox"/> Allergy - Penicillin |
| <input type="checkbox"/> Allergy - Sulfa | <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Artificial Joints |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> HIV | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> No epinephrine | <input type="checkbox"/> Other STD's | <input type="checkbox"/> Other |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Taking Bisphosphonates | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Venereal Disease | | |

Do you have any other health issues or allergies?



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What is the reason for your dental visit today?

What was done on your last dental visit (if to a different office)?

Please answer the following questions Yes or No and if any questions are marked Yes please explain in the space provided at the end of this section.

Do your gums bleed when you brush or floss?

- Yes No

Are your teeth sensitive to hot or cold temperatures?

- Yes No

Are any of your teeth causing you pain?

- Yes No

Do you grind or clench your teeth (either consciously or in your sleep)?

- Yes No

Are any of your teeth loose or are you concerned about tooth loss?

- Yes No

Do you currently have any dental implants, dentures, or partial dentures?

- Yes No

Have you been told recently that you require any dental procedures?

- Yes No



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Please provide explanation here for any previous questions marked Yes

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 dental 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. 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: