

Port Royal Dentistry Medical History Form

Although dental personnel primarily treat the area in and around the mouth, your mouth is a part of your entire body. Health problems that you have, or medications that you may be taking, could have an important interrelationship with the dentistry that you will receive. Thank you for taking the time to complete this form.

Patients Name (please print): _____ **Date of Birth:** _____ **Date:** _____

Are you under a Physician's care now? **Yes** or **No** If **Yes**; physician's name and last visit date: _____

- Are you currently taking any blood thinners? **Yes** or **No**
- Are you currently taking any osteoporosis medications? **Yes** or **No**
- Do you use tobacco products? **Yes** or **No**

Women: Are you.....

- Pregnant/Trying to get pregnant? **Yes** or **No** If **yes**; due date: _____
- If pregnant, please list OBGYN contact information: _____
- Nursing? **Yes** or **No**

ALLERGIES – Select all that apply:

Aspirin	Latex	Local Anesthetics	
Codeine	Penicillin	NSAIDS	
Erythromycin	Sulfa	Seasonal Allergies	

Please list any other allergies you have or N/A for no known allergies: _____

MEDICATIONS: Please list any medications (including vitamins/supplements) you are currently taking. Please provide list if greater than space provided.

MEDICAL CONDITIONS: Check all that apply

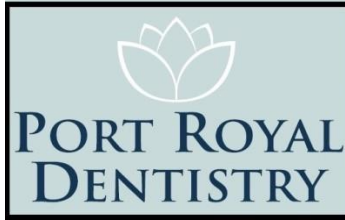
- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Anemia
<input type="checkbox"/> Angina
<input type="checkbox"/> Artificial Heart Valve
<input type="checkbox"/> Blood Disease
<input type="checkbox"/> Congenital Heart Defect
<input type="checkbox"/> Heart Attack, if so, when? _____
<input type="checkbox"/> Heart Condition
<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Heart Surgery
<input type="checkbox"/> Hemophilia
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> Irregular Heart Beat
<input type="checkbox"/> Leukemia
<input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Mitral Valve Prolapse, if so, with or without regurgitation _____
<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Stents
<input type="checkbox"/> Stroke, if so, when? _____
<input type="checkbox"/> Acid Reflux
<input type="checkbox"/> Gastrointestinal Disease
<input type="checkbox"/> GERD
<input type="checkbox"/> Stomach Ulcers
<input type="checkbox"/> AIDS
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Cancer, if yes. List type _____
<input type="checkbox"/> Chemotherapy, if so, when _____
<input type="checkbox"/> Radiation, if so, when? _____ | <input type="checkbox"/> Herpes
<input type="checkbox"/> HIV Positive
<input type="checkbox"/> HPV
<input type="checkbox"/> Rheumatism
<input type="checkbox"/> Scarlet Fever
<input type="checkbox"/> STD
<input type="checkbox"/> Tumors/Growths
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Thyroid Problem
<input type="checkbox"/> Cirrhosis
<input type="checkbox"/> Hep A/B/C
<input type="checkbox"/> Jaundice
<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Liver Disease
<input type="checkbox"/> Asthma
<input type="checkbox"/> Bronchitis
<input type="checkbox"/> COPD
<input type="checkbox"/> Emphysema
<input type="checkbox"/> Mouth Breathing | <input type="checkbox"/> Respiratory Problems
<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Snoring
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Use Inhaler
<input type="checkbox"/> Asperger's
<input type="checkbox"/> Autism
<input type="checkbox"/> Cerebral Palsy
<input type="checkbox"/> Dizzy/Fainting
<input type="checkbox"/> Epilepsy/Seizures
<input type="checkbox"/> Nervous Disorder
<input type="checkbox"/> Artificial Joints
<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Detached Retina
<input type="checkbox"/> Glaucoma |
|--|--|--|--|

Please list any other medical conditions you may have: _____

Consent: *To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status.*

Patient's Signature: (parent if minor)

Date:



Port Royal Dentistry
1869 North Paris Ave.
Port Royal, SC 29935
843.521.1869.

Dental Disclosure Form

I, _____, (**Print Name**) give authorization to Dr. Peipei Yu and/or Port Royal Dentistry staff to release and discuss my dental information with the following:

e.g. Relative or/and friend

1. **Name:** _____ **Relationship to Patient:** _____

Contact Number: _____

2. **Name:** _____ **Relationship to Patient:** _____

Contact Number: _____

3. **Name:** _____ **Relationship to Patient:** _____

Contact Number: _____

Signature

Date



PORT ROYAL DENTISTRY

Information Update:

Name (please print): _____

Preferred Name: _____

Date of Birth: _____

Mailing Address: _____

Phone Number: Cell: _____
Home: _____

Email Address: _____

Emergency Contact: Name: _____
Phone Number: _____
Relationship to Patient: _____

Name of Current Dental Insurance Provider: _____

Patient Signature:

Date: