West Chester Dental Group

5900 West Chester Road | Suite A • West Chester, OH 45069 (513)942-8181

New Patient Medical & Dental History Form

Patient Name: ______________________ ______________________ ____ ______________________
Last First MI Preferred Name

Birth Date: ______________

Within the past year, have there been any changes in your general health? ◯ Yes ◯ No

Please mark any of the following to indicate Yes in response to the question:

- ☐ Have you been hospitalized within the last 5 years due to a surgery or illness?
- ☐ Do you drink alcohol? If so, how much? ______________
- ☐ Do you use tobacco (smoking, chewing, or vaping)?
- ☐ Do you use cannabis?

If any of the previous questions are marked, please explain:

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WOMEN ONLY: Are you pregnant? ◯ Yes ◯ No

If Yes, when is the due date? ______________

What medications are you currently taking? (prescription and over-the-counter)

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Family Physician: ______________________ Phone #: ______________

Are you currently being treated for a specific condition? ______________________

Please indicate if you have experienced any of the following:

◯ Anemia	◯ Aneurism	◯ Arthritis/Rheumatism	◯ Artificial Joints	◯ Asthma
◯ Blood Disease	◯ Cancer	◯ Chemo/Radiation	◯ Cystic Fibrosis	◯ Depression
◯ Diabetes	◯ Emphysema	◯ Epilepsy	◯ Excessive Bleeding	◯ Fainting/Dizziness
◯ Glaucoma	◯ Hay Fever	◯ Heart Condition	◯ Hepatitis	◯ High Blood Pressure
◯ HIV/Aids	◯ Jaundice	◯ Kidney Disease	◯ Liver Disease	◯ Mental Disorders
◯ Mitral Valve Pro	◯ Pacemaker	◯ Respiratory Problems	◯ Rheumatic Fever	◯ Rheumatism
◯ Seizures	◯ Severe/Freq Headache	◯ Sickle Cell Anemia	◯ Sinus Problems	◯ Stomach Problems
◯ Stroke	◯ Thyroid	◯ Tuberculosis	◯ Ulcers/Colitis	◯ Other

If any of the previous questions are marked, please explain:

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Do you have an allergy to any of the following:

◯ Amoxicillin ◯ Aspirin ◯ Augmentin ◯ Bactrim ◯ Biaxin ◯ Ceclor ◯ Codeine
◯ Erythromycin ◯ Latex ◯ Local Anesthetic ◯ Penicillin ◯ Sulfa ◯ Tetracycline ◯ No Allergies
◯ Other

If any of the previous questions are marked, please explain:

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Do you have any dental concerns?

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When was your last dental visit? ________________

Have you had any issues with previous dental treatment?

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☐ **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 detal 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, and I may be billed for this remaining balance. 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:

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Doctor Signature:

Signature ______________________________ **Date** __________

Response Date: ____/____/_______