Medical History

Glenmont Dental/ Michael V.Conte DDS ,PC

Last Name: First: D.O.B:

Do you consider yourself in fairly good health? ☐ Yes ☐ No

In the past year has there been any changes in your general health? ☐ Yes ☐ No

If so, what?:

Are you currently under the care of a physcian? ☐ Yes ☐ No

If so, for what?:

When was your last medical exam?

Have you been hospitalized in the past 5 years for an illness or surgery? ☐ Yes ☐ No

Please list your Primary physician & specialists, names/phone numbers

Please list all prescription & non-prescription medications below

Women Only-are you pregnant? ☐ Yes ☐ No

Do you require corrective lenses/ contact? ☐ Yes ☐ No

Do you use tobacco products? ☐ Yes ☐ No

Have you ever had a bad reaction to a medication or suppliment? ☐ Yes ☐ No

Are you allergic to any medication? ☐ Yes ☐ No

If yes, please list all medications :

Please check if you have or experienced any of the following:

- ☐ Aids,Arc, Hiv Positive
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Liver Disease
- ☐ Venereal Disease
- ☐ Herpes
- ☐ Tuberculosis
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Radiation Treatment
- ☐ Neurological Problems
- ☐ Epilepsy/Seizures
- ☐ Fainting
- ☐ Sleep Disorders
- ☐ Sleep Apnea
- ☐ Migraines
- ☐ Head Injuries
- ☐ Respiratory Problems
- ☐ Asthma
- ☐ Emphysema
- ☐ C.O.P.D
- ☐ Sinus Problems
- ☐ Hay Fever
- ☐ Cardiovascular Disease
- ☐ Angina
- ☐ Arteriosclerosis
- ☐ Stroke
- ☐ Heart Disease/Attack
- ☐ Heart Surgery
- ☐ Congestive Heart Failure
- ☐ Congenital Heart Lesion
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Pacemaker
- ☐ Heart Murmur
- ☐ Artificial Heart Valve
- ☐ Damaged Heart Valve
- ☐ Aneursym
- ☐ Mitral Valve Prolapse
- ☐ Rheumatic Fever
- ☐ Psychiatric Treatment
- ☐ Glaucoma
- ☐ Nervous Disorders
- ☐ Alcoholism
- ☐ Drug Addiction
- ☐ Cosmetic Surgery
- ☐ Apprehensive
- ☐ Kidney Disease
- ☐ Blood Transfusion
- ☐ Bruise Easily
- ☐ Anemia
- ☐ Hemophilia
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Stomach problems
- ☐ Chrones
- ☐ Ulcers
- ☐ Gag Reflex
- ☐ Gerd/Reflux
- ☐ Eating Disorders
- ☐ Artificial Joints
- ☐ Osteoporpsis
- ☐ Arthritis
- ☐ Jaw Joint Pain
- ☐ Autoimmune Disease
- ☐ Rheumatoid Arthritis
- ☐ Lupus
- ☐ Nitrous Oxide Allergy
- ☐ Latex Allergy
- ☐ Allergy To Medications
- ☐ Allergy to anesthetic

Need to Premedicate before dental treatment? Please list the antibiotic that you use in the box provided

Dental History

Glenmont Dental/ Michael V.Conte DDS ,PC

What is the reason for your visit today?

☐ Check Up ☐ Cleaning ☐ Pain ☐ Broken Tooth ☐ Consult

☐ Second Opinion ☐ Other What?:

When was the date of your last dental exam?:

Do your gums bleed when you brush or floss?	☐ Yes	☐ No
Are any of your teeth loose?	☐ Yes	☐ No
Do you have receeding gums?	☐ Yes	☐ No
Does food or floss catch between your teeth?	☐ Yes	☐ No
Is your mouth dry?	☐ Yes	☐ No
Have you been told you have or received treatment for Periodontal Disease?	☐ Yes	☐ No
Have you ever had orthodontic treatment?	☐ Yes	☐ No
Do you have any clicking or popping in your jaw?	☐ Yes	☐ No
Do you grind your teeth during the day or during sleep?	☐ Yes	☐ No
Are you teeth sensitive to cold,hot, sweets or pressure?	☐ Yes	☐ No
Are any of your teeth currently causing you pain?	☐ Yes	☐ No
Do you have any sores re-occuring in your mouth?	☐ Yes	☐ No
Have you had any serious injuries to your head or mouth?	☐ Yes	☐ No
Do you or Has any one told you that you snore?	☐ Yes	☐ No
Have you had any problems with previous dental treatment?	☐ Yes	☐ No

In regards to your mouth and oral health, is there anything you are intersted in finding more about?

☐ Whiter Teeth ☐ Straighter Teeth/Invisalign ☐ Replace Missing Teeth ☐ Tooth Colored Fillings

☐ Oral Appliance for Sleep Apnea ☐ Dental Implants ☐ Mini-Implants to Secure a Denture

☐ Porcelain Veneers ☐ Porcelain Crowns ☐ Dentures ☐ Partial Dentures

☐ Other?

Authorization

To the best of my knowledge, all of the proceeding is true and correct. If I ever have a change in my health, I will inform the office at my next appointment without fail.

I hereby certify that I have read and understand the previous information, 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 the means of radiographs, study models, photographs and other diagnostic aids deemed appropriate.

I authorize Glenmont Dental and it's agents to release my information including diagnosis, records of treatment, examinations, for myself and my dependants, to third party insurance carriers, payors, and/or health care 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 the behalf of my dependants(if any).

Signature:

Date:

Relationship to patient ☐ Self ☐ Parent ☐ Guardian ☐ Other