



THOMAS

DENTAL GROUP

Dental Medical History Form

Please complete all sections. This information is confidential and essential for providing safe, effective dental care.

Patient Information

Patient Name: _____

Date of Birth: _____ Age: _____

Gender: Female Male Non-binary Prefer not to say

Address: _____

City / State / ZIP: _____

Phone: _____ Cell Home Work

Email: _____

Emergency Contact: _____ Phone: _____

Relationship: _____

Dental Health Concerns

Do you have any concerns about your dental health?

Are you experiencing any pain or discomfort? No Yes — Please describe:

Dental History

Date of Last Dental Visit: _____ Reason: _____

Daily Habits

Brush daily Floss regularly Use mouth rinse

Dental Conditions (check all that apply)

- Gum disease / periodontal treatment
- Bleeding gums
- Tooth sensitivity
- Jaw pain / clicking (TMJ)
- Grinding or clenching
- Orthodontic treatment
- Dental implants
- Dentures or partials

 reception@thomasdentalgroup.net

 (330) 492 - 1730

 thomasdentalgroup.net

 4097 Fulton Drive NW Canton, Ohio 44718



Medical History

Primary Care Physician: _____ Phone: _____

Are you currently under medical care? No Yes — Please explain:

Have you had any surgeries? Type and date:

Medical Conditions (check all that apply)

High blood pressure

Heart disease

Heart murmur

Stroke

Diabetes

Asthma

COPD

Sleep apnea

Bleeding disorder

Joint replacement

Type of joint / year replaced: _____

Has your doctor instructed you to take antibiotic premedication for life? No Yes

Medications & Allergies

List all current medications (including supplements):

Do you use tobacco or marijuana? No Yes

Are you allergic to any medications or substances?

Latex

Penicillin

Local anesthetics

Other: _____

Women's Health (if applicable)

Pregnant

Nursing

Trying to become pregnant

Not applicable



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Additional Questions

Is there anything you would like to change about your smile?

Are you interested in sedation for your dental treatment?

Consent & Acknowledgment

I certify that the information I have provided is accurate and complete to the best of my knowledge. I understand that providing

Patient / Guardian Signature: _____ Date: _____

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