Myers Family Dentistry

P: 541-679-4179
F: 541-679-1402

Joshua T. Myers, DDS

90 NW Glenhart Ave
Winston, OR 97496

PATIENT HISTORY

Name: _____ Birth Date: _____ Today's Date: _____
Former Dentist: _____ Date of Dental Visit: _____
Reason for Today's Visit: _____

Circle if you have been experiencing any of the following:

Bad Breath	Grinding Teeth	Sensitivity to Heat	Bleeding Gums	Loose Teeth	Broken Teeth
Sensitivity to Sweets	Clicking or Popping Jaw	Sensitivity to Biting	Food Collection Between Teeth		
Sensitivity to Cold	Sores or Growths in your mouth	Other: _____			

Please circle any you may be interested in:

Whiter Teeth	Replacement of Missing Teeth	Wisdom Teeth Removal	Veneers	Dental Implants
Tooth Colored Fillings	Repair of Broken Teeth	Dentures	Denture Repair	Tighter Dentures

Do you now OR have you ever had any of the following? Please circle "Y" for Yes or "N" for No.

Anemia	Y N	Hepatitis	Y N
Arthritis or Rheumatism	Y N	Hernia Repair	Y N
Artificial Heart Valves	Y N	High Blood Pressure	Y N
Artificial Joints, Pins, etc	Y N	HIV/AIDS	Y N
Asthma	Y N	Jaw Pain	Y N
Back Problems	Y N	Kidney Disease	Y N
Bisphosphonates for Osteoporosis (Fosamax)	Y N	Liver Disease	Y N
Bleeding Abnormalities	Y N	Mitral Valve Prolapse	Y N
Blood Disease	Y N	Pacemaker	Y N
Cancer	Y N	Radiation Treatment	Y N
Chemical Dependency	Y N	Respiratory Disease	Y N
Chemotherapy	Y N	Rheumatic Fever	Y N
Circulatory Problems	Y N	Scarlet Fever	Y N
Congenital Heart Lesions	Y N	Shortness of Breath	Y N
Cortisone Treatments	Y N	Skin Rash	Y N
Persistent Cough	Y N	Stroke	Y N
Cough up Blood	Y N	Swelling of Feet or Ankles	Y N
Diabetes	Y N	Thyroid Problems	Y N
Epilepsy	Y N	Tobacco Habit	Y N
Fainting	Y N	Tonsillitis	Y N
Headaches	Y N	Tuberculosis	Y N
Heart Murmur	Y N	Ulcer	Y N
Heart Problems	Y N	Venereal Disease	Y N
Hemophilia	Y N	Other: _____	Y N

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MEDICAL HISTORY

Physician's Name: _____ Date and Reason for last visit: _____

_____

Have you had any serious illness or surgery in the last two years? Y N Please explain:_____

_____

Woman: Are you pregnant? Y N Due Date: _____ Nursing? Y N

Are you required to take a pre-medication for dental procedures? Y N

Please list all medications you take, including over-the-counter and herbal medicines and their correlating diagnosis:

_____
_____
_____
_____
_____
_____
_____
_____

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient Date

_____ _____

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Signature of Parent, Guardian, or Personal Representative | Relationship to patient | Date