

# Patient Medical History

Physician and Location: \_\_\_\_\_ Office Phone: \_\_\_\_\_ Date of Last Exam: \_\_\_\_\_

- |   | Yes                      | No                       |  | Yes                      | No                       |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Are you under medical treatment now?   | <input type="checkbox"/> | <input type="checkbox"/> | 7. Are you allergic to or have you had any reactions to the following? |                          |                          |
| 2. Are you in good health?  | <input type="checkbox"/> | <input type="checkbox"/> | Local Anesthetics (ex. Novocain)                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever been hospitalized for any surgical operation or illness within the last 5 years? | <input type="checkbox"/> | <input type="checkbox"/> | Penicillin or other antibiotics  | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes please explain: _____  |                          |                          | Sulfa Drugs  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you taking any medication(s) including non-prescription medication(s)? _____               |                          |                          | Barbiturates   | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | Sedatives  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you use tobacco?  | <input type="checkbox"/> | <input type="checkbox"/> | Iodine   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you use controlled substances?  | <input type="checkbox"/> | <input type="checkbox"/> | Aspirin  | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | Any metals (ex. nickel, mercury, etc)                                  | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | 8. Women Only:   |                          |                          |
|   |                          |                          | Are you pregnant or think you may be pregnant? Due date _____          | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | Are you nursing?   | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | Are you taking oral contraceptives?                                    | <input type="checkbox"/> | <input type="checkbox"/> |

- |  | Yes                      | No                       |                      | Yes                      | No                       |                       | Yes                      | No                       |
|--|--------------------------|--------------------------|----------------------|--------------------------|--------------------------|-----------------------|--------------------------|--------------------------|
| 9. Do you have or have you had any of the following? |                          |                          |                      |                          |                          |                       |                          |                          |
| Kidney Diseases                                      | <input type="checkbox"/> | <input type="checkbox"/> | Asthma               | <input type="checkbox"/> | <input type="checkbox"/> | Chest Pains           | <input type="checkbox"/> | <input type="checkbox"/> |
| AIDS or HIV  | <input type="checkbox"/> | <input type="checkbox"/> | Low Blood Pressure   | <input type="checkbox"/> | <input type="checkbox"/> | Stroke                | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid Problem                                      | <input type="checkbox"/> | <input type="checkbox"/> | Cancer               | <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever             | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy   | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis            | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis          | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes   | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever      | <input type="checkbox"/> | <input type="checkbox"/> | Radiation Therapy     | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Disease  | <input type="checkbox"/> | <input type="checkbox"/> | Swollen Ankles       | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma              | <input type="checkbox"/> | <input type="checkbox"/> |
| Cardiac Pacemaker                                    | <input type="checkbox"/> | <input type="checkbox"/> | Joint Replacement    | <input type="checkbox"/> | <input type="checkbox"/> | Recent Weight Loss    | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Murmur   | <input type="checkbox"/> | <input type="checkbox"/> | Implant              | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease         | <input type="checkbox"/> | <input type="checkbox"/> |
| Angina   | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis / Jaundice | <input type="checkbox"/> | <input type="checkbox"/> | Respiratory Problems  | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequently Tired                                     | <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure  | <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse | <input type="checkbox"/> | <input type="checkbox"/> |
| Anemia   | <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack         | <input type="checkbox"/> | <input type="checkbox"/> | PreMed Prior to appt. | <input type="checkbox"/> | <input type="checkbox"/> |
| Emphysema  | <input type="checkbox"/> | <input type="checkbox"/> | Stomach Troubles     | <input type="checkbox"/> | <input type="checkbox"/> | Other _____           | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting / Seizures                                  | <input type="checkbox"/> | <input type="checkbox"/> | Easily Winded        | <input type="checkbox"/> | <input type="checkbox"/> |                       |                          |                          |

## Patient Dental History

Name of previous dentist and Location: \_\_\_\_\_ Date of Last Exam: \_\_\_\_\_

- |  | Yes                      | No                       |  | Yes                      | No                       |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Do your gums bleed while brushing or flossing?                  | <input type="checkbox"/> | <input type="checkbox"/> | 13. Have you ever had Braces?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are your teeth sensitive to hot or cold foods?                  | <input type="checkbox"/> | <input type="checkbox"/> | 14. Do you wear dentures or partials?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Did you know that poor oral health affects your heart?          | <input type="checkbox"/> | <input type="checkbox"/> | If Yes, date of placement _____  |                          |                          |
| 4. Do you feel pain to any of your teeth?                          | <input type="checkbox"/> | <input type="checkbox"/> | 15. Do you like your smile?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have sores or lumps in your mouth?                       | <input type="checkbox"/> | <input type="checkbox"/> | 16. Are you interested in braces?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any head, neck or jaw injuries?                    | <input type="checkbox"/> | <input type="checkbox"/> | 17. Do you still have your wisdom teeth?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you experienced any of the following Problems in your jaw? |                          |                          | 18. Are you interested in bleaching?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Clicking   | <input type="checkbox"/> | <input type="checkbox"/> | 19. Have you been treated for periodontal disease in the past?   | <input type="checkbox"/> | <input type="checkbox"/> |
| Pain (joint, ear, side of face)                                    | <input type="checkbox"/> | <input type="checkbox"/> | I acknowledge that I have answered all questions to the best of my knowledge and everything herein is true and correct and understand that anything not disclosed to Dr. Menard could be dangerous to my health. |                          |                          |
| Difficulty opening or closing                                      | <input type="checkbox"/> | <input type="checkbox"/> | _____<br>Sign  | _____<br>Date            |                          |
| 8. Do you have frequent headaches?                                 | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| 9. Do you clench or grind your teeth?                              | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| 10. Do you bite your lips or cheeks frequently?                    | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| 11. Have you ever had a difficult extraction?                      | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| 12. Have you had prolonged bleeding following extractions?         | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |



**Dr. Dirk S. Menard, DMD**  
**Nanook Dental**

**Patient Information (CONFIDENTIAL)**

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Nick Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Soc. Sec. # \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City/Zip \_\_\_\_\_  
E-Mail: \_\_\_\_\_ Employer: \_\_\_\_\_ Yrs. Employed \_\_\_\_\_  
Check Appropriate Box:      Minor    Single    Married    Divorced    Widowed    Separated  
If Student Name of School/College: \_\_\_\_\_ City/State \_\_\_\_\_    Full Time    Part Time  
Spouse, Parents, or Nearest Relative Name: \_\_\_\_\_ Contact Number: \_\_\_\_\_  
Contact in Case of Emergency: \_\_\_\_\_ Contact Number: \_\_\_\_\_  
Whom May We Thank for Referring You? \_\_\_\_\_

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**Responsible Party**

Name of Person Responsible for this Account if Other Than You: \_\_\_\_\_  
Address: \_\_\_\_\_ City/Zip: \_\_\_\_\_ Contact Number: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ Soc. Sec. #: \_\_\_\_\_ Employer: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Currently a patient in our office?    Yes    No

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**Dental Insurance Information**

Name of person Carrying Insurance: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Soc. Sec. #: \_\_\_\_\_ Name of Employer: \_\_\_\_\_ Union or Local #: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Relationship to Patient:    Self    Spouse    Child    Other: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Group #: \_\_\_\_\_ Policy/ID #: \_\_\_\_\_  
Insurance Company Address: \_\_\_\_\_ Insurance Company Phone Number: \_\_\_\_\_

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Do You Have Any Additional Dental Insurance:    Yes    No    If yes complete the following:

Name of person Carrying Insurance: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Soc. Sec. #: \_\_\_\_\_ Name of Employer: \_\_\_\_\_ Union or Local #: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Relationship to Patient:    Self    Spouse    Child    Other: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Group #: \_\_\_\_\_ Policy/ID #: \_\_\_\_\_  
Insurance Company Address: \_\_\_\_\_ Insurance Company Phone Number: \_\_\_\_\_

**Authorization and Release**

*I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during periods of such dental care to third party payor and / or health practioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on my behalf or my dependents. If there is anything I do not understand regarding my dental treatment or bill, I will ask someone.*

Patient Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to patient (if filled out and signed by a representative of patient) \_\_\_\_\_

## Our Policy of Care and Payment

Ensuring that patients receive high quality care is the goal of our practice.

Payment is due at the time of treatment. We accept cash, check, and major credit cards. We also have a payment plan called Care Credit, which allows you to start treatment today and spread payments over time.

Payment Option:

- \*Cash or Check
- \*Visa or Mastercard
- \*CareCredit

Please indicate below the form of payment you choose to settle your account:

Cash or Check

Visa or Mastercard

CareCredit (Subject to Credit Approval) If credit application is declined, another form of payment listed above is required.

Should this account be turned over to a collection agency the patient will assume responsibility for any fees that the collection agency charges to Nanook Dental.

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Signature of Patient/Responsible Party

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Date