MEDICAL HISTORY

Your current physical health is:

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Are you taking any prescription, over-the-counter, or herbal supplement drugs? ☐ Yes ☐ No

Please list each one _____

_____

Have you ever taken Phen-Fen? ☐ Yes ☐ No

If so, when? _____

For Women: Are you pregnant? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Y N Abnormal Bleeding	Y N Hepatitis
Y N Alcohol/Drug Abuse	Y N Herpes
Y N Anemia	Y N High Blood Pressure
Y N Arthritis	Y N HIV+ / AIDS
Y N Asthma	Y N Kidney Problems
Y N Artificial Joints	Y N Liver Disease
Y N Blood Transfusion	Y N Low Blood Pressure
Y N Cancer/Chemotherapy	Y N Mitral Valve
Y N Colitis	Y N Pacemaker
Y N Heart Defect	Y N Radiation Therapy
Y N Diabetes	Y N Rheumatic Fever
Y N Respiratory Disease	Y N Seizures
Y N Emphysema	Y N Shingles
Y N Epilepsy	Y N Sickle Cell Anemia
Y N Fainting Spells	Y N Sinus Problems
Y N Headaches	Y N Stroke
Y N Glaucoma	Y N Thyroid Problems
Y N Hay Fever	Y N Tuberculosis
Y N Heart Attack	Y N Ulcers
Y N Heart Surgery	Y N Venereal Disease
Y N Hemophilia	Y N Healing Complications

Please list any serious medical conditions _____

_____

Are you allergic to any of the following?

Aspirin	Erythromycin	Metals
Codeine	Jewelry	Penicillin
Dental Anesthetics	Latex	Tetracycline

Please list any drugs/materials that you are allergic to____

_____

DENTAL HISTORY

Why have you come to the dentist today?_____

_____

Do you require antibiotics before treatment? Y N

Are you currently in pain? Y N

Do your gums ever bleed? Y N

Have you ever had a serious problem associated with any previous dental work? Y N

Do you ever have pain in your jaw joint (TMJ)? Y N

Your current dental health is: GOOD FAIR POOR

Do you like your smile? Y N

Would you like whiter teeth? Y N

Would you like fresher breath? Y N

How many times a day do you brush? _____

How many times a week do you floss? _____

Do you smoke or use tobacco? Y N

Does food catch between your teeth? Y N

Present conditions…..(please circle)

Swelling Bleeding Gums Unpleasant odor or taste

Sensitivity to…Hot Cold Sweets Biting pressure

Do you get frustrated because you always have something to be repaired or treated when you visit the dentist? Y N

Do you feel that you will eventually wear dentures? Y N

Do you have any dental fears? Y N

Please explain_____

I understand that the information I have given today is correct to the best of my knowledge and that it is my responsibility to inform this office of any change in my medical status.

I have been informed of the dental materials fact sheet and authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment.

I understand that I am responsible for payment of services rendered.

Our office is HIPAA compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

_____

Signature **Date**

ABOUT YOU

Today's Date _____

Name _____

I prefer to be called _____ M___ F____

Birthdate ___/___/_____ SS# _____

Home Address _____

_City_____ Zip_____

E-Mail Address _____

☐ Single ☐ Married ☐Divorced ☐ Widowed

Home # (____)_____ Cell # (___)_____

Work # (____)_____ Ext.____

Driver's License # _____

Employer _____

Employer's Address _____

How long there? _____ Occupation _____

Where and when are the best times to reach you?

_____

Whom may we thank for referring you?

_____

Last Dental Visit _____

SPOUSE INFORMATION

His/Her Name _____

Employer _____

Work # (____) _____ Cell#(___)_____

SS# _____

Birthdate ___/___/_____ CDL# _____

PERSON RESPONSIBLE FOR ACCOUNT

_____

Billing Address _____

_____

Relationship to Patient _____

SS# _____ CDL# _____

Employer _____

Work # ( ) Cell# ( )

INSURANCE COVERAGE

Primary

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # (____)_____

Group or Plan # _____

Insured's Name _____

Relationship to Patient _____

Insured's Birthdate ___/___/_____ SS# _____

Insured's Employer _____

Secondary

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # (____)_____

Group or Plan # _____

Insured's Name _____

Relationship to Patient _____

Insured's Birthdate ___/___/_____ SS# _____

Insured's Employer _____

In the event of an emergency, is there someone who lives near you that we should contact?

Name _____

Relationship _____

Home # (____)_____ Wk# (____)_____

MEDICAL HISTORY

Do you have a personal Physician? ☐Yes ☐No

Physician's Name _____

Phone # (____)_____

Date of last visit _____

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

Please explain _____

_____

_____

Please continue on reverse……..