5 Medical History

Are you currently under the care of a physician? ❑ Yes ❑ No
Physician's Name: _____
Phone #: (____)_____ Date of last visit: _____
Your current physical health is ❑ good ❑ fair or ❑ poor
Have you ever had any metal rods, pins, or implants? ❑ Yes ❑ No
Have you ever taken Fen-Phen/Redux? ❑ Yes ❑ No
Have you ever used a bisphosphonate medication? ❑ Yes ❑ No
(Fosamax, Actonel, Atelvia, Didronel or Bonivia) ❑ IV ❑ Oral
If yes, frequency & how long?_____
Are you taking any prescription or over the counter drugs? ❑ Yes ❑ No
Please list each one_____
Do you smoke tobacco or any recreational drugs? ❑ Yes ❑ No
Are you on or have been on corticosteroid medication? ❑ Yes ❑ No
Are you allergic to any of the following?

Y N Aspirin	Y N Penicillin	Y N Dental anesthetics
Y N Codeine	Y N Tetracycline	Y N Jewelry/metals
Y N Latex	Y N Erythromycin	Y N NSAIDS/Ibuprofen

Please list any drugs/materials that you are allergic to_____

PHYSICAL EVALUATION:
Wt_____Ht_____Age_____Asa_____Bp_____Pulse_____

Have you ever had any of the following diseases or medical problems?

Y N Abnormal Bleeding	Y N Epilepsy	Y N Mitral Valve Prolapse
Y N Alcohol/Drug Abuse	Y N Fainting Spells	Y N Pacemaker
Y N Anemia	Y N Frequent Headaches	Y N Psychiatric Problems
Y N Anaphylaxis	Y N Glaucoma	Y N Radiation Treatment
Y N Arthritis	Y N Hay Fever	Y N Respiratory Disease
Y N Artificial Bone/Joints/Valves	Y N Heart Attack	Y N Rheumatic Fever
	Y N Heart Surgery	Y N Seizures
Y N Asthma	Y N Heart Murmur	Y N Shingles
Y N Blood Disease	Y N Hepatitis	Y N Shortness of Breath
Y N Blood Transfusion	Y N Herpes/Fever Blisters	Y N Sickle Cell Disease
Y N Cancer/Chemotherapy	Y N High Blood Pressure	Y N Sinus Problems
Y N Congenital Heart Disease	Y N HIV	Y N Stroke
	Y N Hospitalization	Y N Surgical Implant
Y N Cough Up Blood	Y N Kidney Problems	Y N Thyroid Disease/Malfn
Y N Diabetes	Y N Liver Disease	Y N Tuberculosis
Y N Difficulty Breathing	Y N Low Blood Pressure	Y N Ulcers/Colitis
Y N Emphysema	Y N Lupus Erythematous	Y N Venereal Disease

Details of any serious medical conditions/operations ever had_____

WOMEN:
Are you pregnant? ❑ Yes ❑ No Week#_____
Are you nursing? ❑ Yes ❑ No
Taking birth control pills? ❑ Yes ❑ No

6 Dental History

What is the purpose of your dental visit?_____
Are you in any discomfort today?_____
Former dentist name:_____PH#:_____
Approx date of last dental care:_____
Date of last x-rays:_____
Any past negative dental experience?_____
_____
(We ask so that you dont have a repeat experience at our office)
Is there any special limitations that might stop you from having dental care? (time, money, fear of pain):_____
If you could change anything about your teeth what would it be?:
_____
Do you require antibiotics before dental treatment? ❑ Yes ❑ No

PLEASE CHECK YES OR NO IF YOU HAVE HAD PROBLEMS WITH ANY OF THE FOLLOWING:

Adverse reaction during or in conjunction with a medical or a dental procedure?	❑ Yes	❑ No
Sensitive teeth to hot, cold or anything else?	❑ Yes	❑ No
Bad breath/food collection between teeth?	❑ Yes	❑ No
Bleeding gums?	❑ Yes	❑ No
Any gum treatment?	❑ Yes	❑ No
Do you grind or clench your teeth?	❑ Yes	❑ No
Do you brush/floss daily?	❑ Yes	❑ No
Would you like whiter teeth?	❑ Yes	❑ No
Would you like straighter teeth?	❑ Yes	❑ No

7 Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

_____
Signature Date

Office Use Only

I verbally reviewed the medical/dental information above with the patient named herein.

Initials:_____Date:_____

Doctor's Comments:_____
_____

8 Medical History Update For Future Use

Has there been any changes in your health status since your last visit? ❑ Yes ❑ No
If yes, please explain._____

Next Year:
Has there been any changes in your health status since your last visit? ❑ Yes ❑ No
If yes, please explain._____

Patient Signature	Date
Dentist Signature	Date
Patient Signature	Date
Dentist Signature	Date

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

1 About You

Today's Date: _____

Name: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____ ❑ Male ❑ Female

Birth date: ___/___/___ Age: _____ SS #: _____

Email address: _____

Home address: _____

_____
CITY STATE ZIP

❑ Single ❑ Married ❑ Partnered ❑ Divorced/Separated ❑ Widowed

Cell #: (____)_____ Home/Other #: _____

Wk #: (____)_____ Ext: _____ DL #: _____

Employer: _____

Employer's address: _____

_____
CITY STATE ZIP

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____

Person responsible for account: _____

2 Spouse Information

Name: _____

Phone #: _____

Emergency Contact:

Name: _____

Phone # _____

3 Insurance Coverage

PRIMARY INSURANCE

Dental Coverage: ❑ Yes ❑ No

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
CITY STATE ZIP

Insurance Co. Phone #: (____)_____

Group # (plan, local or policy #): _____

Insured's name: _____ Relation: _____

Insured's birth date: ___/___/___ Insured's ID #: _____

Insured's employer: _____

Person responsible for account:

Name: _____ Phone: _____

SECONDARY INSURANCE

Dental Coverage: ❑ Yes ❑ No

Insurance Co. Name: _____

Insured's Name: _____ Relation: _____

Insured's birth date: ___/___/___ Insured's ID #: _____

4 Payment

PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the dental office of the group benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____
Signature Date

PLEASE COMPLETE BOTH SIDES

CONTINUED ON BACK