PATIENT MEDICAL HISTORY

Physician name _____ Phone _____ Last Health Care Exam Date _____

If you have been hospitalized within the past 5 years please state a reason._____

	YES	NO
1. Are you presently under a physicians' care?	**( )**	**( )**
If yes, why _____		
2. Are you taking any medications, including vitamins, fluoride, birth control pill, anticoagulants, tranquilizers, insulin, cortisone, aspirin, antibiotics, B/P medicine? If yes please list:	**( )**	**( )**
3. Have you ever had any Bisphosphonates (for osteoporosis), either orally or by injection?	**( )**	**( )**
4. Have you had any major operations?	**( )**	**( )**
If yes, what? _____		
5. Have you ever had a serious accident involving head injuries?	**( )**	**( )**
6. Are you allergic to any medications?	**( )**	**( )**
Please list _____		
7. Are you allergic to any known foods resulting in hives, eczema, etc.?	**( )**	**( )**
If yes, what? _____		
8. Are you in good health at this time?	**( )**	**( )**
9. Have any wounds healed slowly or presented complications in healing or would not stop bleeding, including extractions?	**( )**	**( )**

10. Women: <u>Are you pregnant?</u> Yes/No Due date? _____

11. Has a physician ever informed you that you had any of the following: Yes/No

***<u>Please circle.</u>* If so indicate date _____**

A Heart Ailment Diabetes Cancer/Tumors or Growths Anemia Sinus Problems
Epilepsy Rheumatic Fever Respiratory Disease Hepatitis (A, B, C) Arthritis
High Blood Pressure Osteoporosis Unexplained Weight Loss Blood Disorders
Swollen Glands HIV/Positive Aids Asthma Other_____

12. Do you currently use or have you been treated for addiction to street drugs?	**( )**	**( )**
13. Do you have any prosthetic devices - limbs, joints, pacemaker, or an artificial heart valve?	**( )**	**( )**

If yes, what and when was it done? _____

14. Do you use tobacco or marijuana products? Yes/No

How much? _____ What kind? _____

15. Do you consume alcohol? Yes/No How much? _____

Patient Registration

Date _____

Patient Name _____ Birthdate _____ Age_____

Home Phone _____ Cell Phone _____ E-mail _____

Previous Dentist _____ City _____ Last Exam and Cleaning _____

Reason for Leaving _____ Purpose of Todays Visit- (Exam and Cleaning, Toothache, Other)

Person Responsible for Account

Name _____ Birthdate _____ SS#_____

Spouse's Name _____ Birthdate _____ SS#_____

Mailing Address_____ City _____ Zip _____

How long at present address? _____

In case of Emergency please notify _____Relationship_____ Phone _____

Employer_____ Address_____ Phone_____

Spouse's Employer_____ Address _____ Phone_____

Primary Insurance Subscriber_____

Secondary Insurance Subscriber_____

Insurance Company_____ Group #_____ ID #_____

2nd Insurance Company_____ Group # _____ ID#_____

Patient Dental History

1. Are you apprehensive about dental treatment? Yes/No
2. Have you had problems with previous treatment? Yes/No
3. What would you like to change about your teeth? _____
4. Are you interested in bleaching your teeth? Yes/No
5. Do you have frequent headaches? Yes/No
6. Do your gums bleed? Yes/No
7. How often do you brush? _____ Floss? _____
8. What type of toothbrush do you use? (Manual, Electric) (Soft, Hard, Medium)
9. Have you experienced any growths or sore spots in your mouth? Yes/No Where/When_____
10. Is any part of your mouth sore to pressure or irritants (cold, warm, sweet, etc.)? Yes/No
11. Do you have pain or clicking in your jaw? Yes/No
12. In back teeth do you prefer white or silver fillings? _____