Welcome to our Dental Office

Medical Alert

Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. **The patient is an Adult ☐ Child ☐**

Name: (Last) (First) (Initial) ______ Prefer to be called: ______

Address: (Street) (Apt #) (City) (Postal Code) ______

Home ☎ (____) ____ - ______ Work ☎ (____) ____ - ______ Date of Birth: M ____ D ____ Y ____

Fax: (____) ____ - ______ Other ☎ (____) ____ - ______ ☐ Male ☐ Female

Employer / School: ______ Occupation: ______

eMail: ______ Whom may we thank for referring you to this office?: ______

Health Card # ______

Family Physician: ______ ☎ (____) ____ - ______

In Case of Emergency Notify: ______ Relation: ______ ☎ (____) ____ - ______

Person responsible for this account: ☐ Self ☐ Spouse ☐ Parent ☐ Legal Guardian ☐ Other

Name: (Last) (First) (Initial) ______ Relation: ______

Address: (Street) (Apt #) (City) (Postal Code) ______

Home ☎ (____) ____ - ______ Work ☎ (____) ____ - ______ Drivers License Number ______

Method pf Payment ☐ Cash ☐ Debit ☐ Credit Card: ______ Number: ______ Exp: ______

PRIMARY INSURANCE

Subscriber: ______

Relation: ☐ Self ☐ Spouse Other: ______

Insurance Co: ______

Policy/Plan #: ______ Division/Sect. #: ______

Subscriber I.D.: ______

SECONDARY INSURANCE

Subscriber: ______

Relation: ☐ Self ☐ Spouse Other: ______

Insurance Co: ______

Policy/Plan #: ______ Division/Sect. #: ______

Subscriber I.D.: ______

MEDICAL HISTORY Please ☑ YES or NO to each question.

All information is confidential

The following information is required by the dentist to assist in proper diagnosis and treatment.

	YES	NO
1. Have you ever had a serious illness requiring hospitalization or extensive medical care? Please specify: ______	☐	☐
2. Are you presently under the care of a physician? If so, please explain: ______	☐	☐
3. Have you had a medical examination in the last year?	☐	☐
4. Do you use any prescription or non-prescription drugs regularly? Please specify: ______	☐	☐
5. Do you have any allergic conditions: e.g. hay fever, skin rash, food allergies, metal, latex?	☐	☐
6. Do any allergic reactions result in headaches, shortness of breath, chest constriction, nausea? Please specify: ______	☐	☐
7. Have you been hospitalized in the last 5 years? Please specify: ______	☐	☐
8. Have you ever experienced any unusual reaction to any of the following? (Please circle) local anaesthesia (freezing), aspirin, penicillin, codeine, sulpha drugs, barbiturates (sleeping pills), or or any other medicine? If so please explain ______	☐	☐
9. Have you been warned against taking any drug or medication?	☐	☐
10. Do you bruise easily or bleed abnormally?	☐	☐

PATIENT REGISTRATION **MEDICAL / DENTAL HISTORY**

MEDICAL HISTORY (Cont'd) Please ☑ YES or NO to each question.

Question	YES	NO
11. Have you ever had any organ implants or medical implants?	☐	☐
12. Have your ever fainted?	☐	☐
13. Do your ankles, feet or hands swell?	☐	☐
14. Do you experience shortness of breath or chest pain when taking a walk or climbing stairs?	☐	☐
15. Do you have frequent headaches?	☐	☐
16. Do you have A.I.D.S. or have you ever tested positive for H.I.V.?	☐	☐
17. Do you have or ever had any of the following?	☐	☐

☐ Heart murmur or Mitral valve Prolapse	☐ Malignant Hyperthermia	☐ Liver Disease	☐ Herpes
☐ Stomach / Intestinal problems	☐ Drug / Alcohol Dependency	☐ Heart Attack	☐ Sinus Trouble
☐ Joint Replacement (hip, knee, etc)	☐ Venereal Disease	☐ Cold sores	☐ Stroke
☐ Mental or nervous Disorder	☐ Lung Disease (i.e. Asthma)	☐ Juandice	☐ Kidney problems
☐ High/low Blood Pressure	☐ Thyroid Disease	☐ Diabetes	☐ Emphysema
☐ Hyper (hypo) Glycemia	☐ Arthritis or Rheumatism	☐ Tuberculosis	☐ Glaucoma
☐ Epilepsy or Seizures	☐ Scarlet or Rheumatic fever	☐ Hepatitis A, B, C	
☐ Cortisone/Steroid Therapy	☐ Cancer / Chemotherapy	☐ Other: ______	

Question	YES	NO
18. Have you had any injury, surgery or x-ray therapy to your face or jaw?	☐	☐
19. Do you have any disease, condition, or problem that you think the doctor should know about?	☐	☐
20. WOMEN ONLY: Are you pregnant or suspect you might be? If so, what month are you in? ______	☐	☐
Are you taking birth control pills?	☐	☐

DENTAL HISTORY Please ☑ YES or NO to each question.

Question	YES	NO
1. Reason for today's visit: ☐ Exam ☐ Cleaning ☐ Emergency ☐ Other ______		
Are you presently having dental pain?	☐	☐
Is there a dental problem you would like to take care of as soon as possible?	☐	☐
2. How frequently do you see your dentist? ☐ 6 months ☐ Yearly ☐ Other ______		
Previous Dentist: ______ Last dental visit: ______		
Last cleaning: ______ Full mouth series of x-rays: ______		
3. How often do you brush your teeth? ______ Floss? ______ Do you feel you have bad breath?	☐	☐
4. Do your gums bleed easily?	☐	☐
5. Are your teeth sensitive to: ☐ Hot ☐ Cold ☐ Biting ☐ Sweets?	☐	☐
6. Do you smoke or use any other forms of tobacco?	☐	☐
7. Have you ever had jaw / joint surgery?	☐	☐
8. Do you have pain in your jaw joints or suffer from migraine headaches?	☐	☐
9. Does any part of your mouth hurt when clenched?	☐	☐
10. Does you jaw crack or pop when opened widely?	☐	☐
11. Have you had: ☐ Braces ☐ Oral Surgery ☐ Gum treatment ☐ Root Canal	☐	☐
12. Do you grind or clench your teeth during the day or night?	☐	☐
13. Have you ever experienced any growths or sore spots in the mouth? If so, where?	☐	☐
14. Previous problems with dental treatment?	☐	☐
15. Are you satisfied with the appearance of your teeth?	☐	☐
16. Please list any other dental concerns or question: ______		

Office policy: Your appointment time will be reserved especially for you, If you are unable to keep the appointment we will require **48 hours** notice, otherwise it may be necessary to charge for the time lost.

Patient Release: I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I have had the opportunity to ask questions and receive answers to any questions regarding my medical-dental history. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I also understand that consultation with my medical doctor may be required, and I consent to my physician being contacted as necessary. I understand that responsibility for payment for the dental services provided for myself and my dependents is mine, and I will assume responsibility for fees associated with these services.

______ (Signature) ☐ Patient ☐ Parent ☐ Guardian

______ Reviewing Dentist

Please print name: ______ Date: ______