MEDICAL DENTAL HISTORY ODONTOLOGICA

Welcome to our office! To assist us in serving you, please complete the following confidential form.
The information provided is important to your dental health.

Patient's name ____________________ Preferred name ____________ Birth date__________

If minor, parents names ____________________ Home phone __________ Work phone __________

Mailing address ____________________ City ____________State ________ Zip __________

Employer ____________________ Occupation ____________________

Spouse's name ____________________ Spouse's employer ____________________ ❑ Unmarried

Whom may we thank for referring you to our office? ____________________ ❑ Phonebook

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ Not covered by dental insurance

Your Social Security number: ______________ Dental Insurance Co.____________ Group number__________

Covered by spouse's insurance? ❑ yes ❑ no

Spouse's dental insurance company ______________ Group number ____________

Spouse's birthday ______________ Social Security number ______________

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ Cancer or tumor
- ❑ Heart ailment or angina
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Rheumatic fever or rheumatic heart disease
- ❑ Artificial joint or valve
- ❑ High or low blood pressure
- ❑ Pacemaker
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis or other liver disease
- ❑ Alcoholism
- ❑ Blood transfusion
- ❑ Diabetes
- ❑ Neurologic condition
- ❑ Epilepsy, seizures, or fainting spells
- ❑ Emotional condition
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Migraine headaches or frequent headaches
- ❑ Anemia or blood disorders
- ❑ Abnormal bleeding after extractions, surgery, or trauma
- ❑ Hayfever or sinus trouble
- ❑ Allergies or hives
- ❑ Asthma

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:____________________

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Other:____________________
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Women:

- ❑ May be pregnant
  Expected delivery date: __________
- ❑ Taking hormones or contraceptives

Name of your physician:____________________

Do you have any disease, condition, or problem not listed above?____________________

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Please add anything else you would like us to know about:____________________

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Informed Consent

1.The undersigned hereby authorizes the doctor for x-rays, to study prototypes, photographs or other assistance deemed appropriate for the diagnosis of the patient's dental needs.

2. I also authorize doctor to perform all recommended treatment mutually agreed upon and to use the medicines necessary to treat the patient…………………………………………… I understand that using anesthetic agents involves certain risks. You authorize and consent that Doctor choose and employ the assistance they deem necessary to provide adequate treatment.

3. I understand it is my responsibility to inform staff of any change in the information collected on this form.

Parent or responsible person (minors) ___________________________________ Date ______