

**MEDICAL HISTORY**

DATE \_\_\_\_\_

PATIENT NAME \_\_\_\_\_ Birth Date \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_
- Are you taking any medications, pills, or drugs?  Yes  No If yes, please explain: \_\_\_\_\_
- Do you take, or have you taken, Phen-Fen or Redux?  Yes  No \_\_\_\_\_
- Are you on a special diet?  Yes  No \_\_\_\_\_
- Do you use tobacco?  Yes  No \_\_\_\_\_
- Do you use controlled substances?  Yes  No \_\_\_\_\_

Women: Are you

Pregnant/Trying to get pregnant?  Yes  No Taking oral contraceptives?  Yes  No Nursing?  Yes  No

Are you allergic to any of the following?

- Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics
- Other If yes, please explain: \_\_\_\_\_

Do you have, or have you had, any of the following?

- |  |  |  |   |
|--|--|--|---|
| AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No         | Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No        | Hemophilia <input type="radio"/> Yes <input type="radio"/> No            | Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No             |
| Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No       | Diabetes <input type="radio"/> Yes <input type="radio"/> No                  | Hepatitis A <input type="radio"/> Yes <input type="radio"/> No           | Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No            |
| Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No               | Drug Addiction <input type="radio"/> Yes <input type="radio"/> No            | Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No      | Rheumatism <input type="radio"/> Yes <input type="radio"/> No                 |
| Anemia <input type="radio"/> Yes <input type="radio"/> No                    | Easily Winded <input type="radio"/> Yes <input type="radio"/> No             | Herpes <input type="radio"/> Yes <input type="radio"/> No                | Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No              |
| Angina <input type="radio"/> Yes <input type="radio"/> No                    | Emphysema <input type="radio"/> Yes <input type="radio"/> No                 | High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No   | Shingles <input type="radio"/> Yes <input type="radio"/> No                   |
| Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No            | Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No      | Hives or Rash <input type="radio"/> Yes <input type="radio"/> No         | Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No        |
| Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No    | Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No        | Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No          | Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No              |
| Artificial Joint <input type="radio"/> Yes <input type="radio"/> No          | Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No          | Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No   | z Bifida <input type="radio"/> Yes <input type="radio"/> No                   |
| Asthma <input type="radio"/> Yes <input type="radio"/> No                    | Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems <input type="radio"/> Yes <input type="radio"/> No       | Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease <input type="radio"/> Yes <input type="radio"/> No             | Frequent Cough <input type="radio"/> Yes <input type="radio"/> No            | Leukemia <input type="radio"/> Yes <input type="radio"/> No              | Stroke <input type="radio"/> Yes <input type="radio"/> No                     |
| Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No         | Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No         | Liver Disease <input type="radio"/> Yes <input type="radio"/> No         | Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No          |
| Breathing Problem <input type="radio"/> Yes <input type="radio"/> No         | Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No        | Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No    | Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No            |
| Bruise Easily <input type="radio"/> Yes <input type="radio"/> No             | Genital Herpes <input type="radio"/> Yes <input type="radio"/> No            | Lung Disease <input type="radio"/> Yes <input type="radio"/> No          | Tonsillitis <input type="radio"/> Yes <input type="radio"/> No                |
| Cancer <input type="radio"/> Yes <input type="radio"/> No                    | Glaucoma <input type="radio"/> Yes <input type="radio"/> No                  | Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis <input type="radio"/> Yes <input type="radio"/> No               |
| Chemotherapy <input type="radio"/> Yes <input type="radio"/> No              | Hay Fever <input type="radio"/> Yes <input type="radio"/> No                 | Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No    | Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No          |
| Chest Pains <input type="radio"/> Yes <input type="radio"/> No               | Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No      | Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No   | Ulcers <input type="radio"/> Yes <input type="radio"/> No                     |
| Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur <input type="radio"/> Yes <input type="radio"/> No              | Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No      | Venereal Disease <input type="radio"/> Yes <input type="radio"/> No           |
| Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No | Heart Pace Maker <input type="radio"/> Yes <input type="radio"/> No          | Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No  | Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No            |
| Convulsions <input type="radio"/> Yes <input type="radio"/> No               | Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No     | Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No    |   |

Have you ever had any serious illness not listed above?  Yes  No If yes, please explain: \_\_\_\_\_

**Oral Health History**

- Previous Dentist: \_\_\_\_\_ City: \_\_\_\_\_ Phone: \_\_\_\_\_
- Date of Last Check-up/X-rays: \_\_\_\_\_ Do You have a pre-medicate (take antibiotic) before dental treatment? Y - N
- Does dental treatment make you nervous? Y- N Explain: \_\_\_\_\_
- Are you satisfied with the appearance of you teeth? Y- N If not, what would you change? \_\_\_\_\_
- Are you sensitive to: HOT, COLD, SWEETS, BITING, CHEWING, Where? \_\_\_\_\_ Do you have dental pain at this time? Y - N
- How Often do you brush? \_\_\_\_\_ How often do you floss? \_\_\_\_\_
- What type of toothbrush do you use? \_\_\_\_\_ Soft \_\_\_ Medium \_\_\_ Hard \_\_\_ Electric \_\_\_
- Do you have, or have had, any of the following?
- |   |                     |   |                          |
|---|---------------------|---|--------------------------|
| Y - N Bleeding ? Sore Gums                          | Y - N Bad Breath    | Y - N Burning tongue or lips            | Y - N Loose Teeth        |
| Y - N Swollen Gums                                  | Y - N Dry Mouth     | Y - N Frequent blisters on lips / mouth | Y - N Headaches          |
| Y - N Food Impaction                                | Y - N Floss Catches | Y - N Orthodontic Treatment             | Y - N Mouth Breather     |
| Y - N Uncomfortable bite                            | Y - N Clenching     | Y - N Wisdom teeth removed              | Y - N Grinding           |
| Y - N Difficulty in jaw (clicking / popping / pain) |                     |   | Y - N Head / Neck Injury |

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

### ***Patient's General Information***

Patient's Name : \_\_\_\_\_ Date of Birth : \_\_\_\_/\_\_\_\_/\_\_\_\_

If patient is minor, responsible party : \_\_\_\_\_ Phone : \_\_\_\_\_

Home Address : \_\_\_\_\_ Apt : \_\_\_\_\_ City : \_\_\_\_\_ Zip : \_\_\_\_\_

Home # : \_\_\_\_\_ Wk # : \_\_\_\_\_ Cell # : \_\_\_\_\_

Employer : \_\_\_\_\_ Occupation : \_\_\_\_\_ Employer Address : \_\_\_\_\_

Email : \_\_\_\_\_@\_\_\_\_\_

Status : MINOR SINGLE MARRIED LONG TERM PARTNER DIVORCED WIDOWED SEPARATED

Emergency Contact Name : \_\_\_\_\_ Relation : \_\_\_\_\_ Phone # : \_\_\_\_\_

How did you hear about us / referred by? Name \_\_\_\_\_ Insurance Co. \_\_\_ Dentist \_\_\_ Web Site \_\_\_  
Other : \_\_\_\_\_

### ***Insurance Information***

**Primary:** Insurance Company Name / Phone

\_\_\_\_\_  
\_\_\_\_\_

Insured Employer: \_\_\_\_\_

Insured Soc Sec #: \_\_\_\_\_

Group Number: \_\_\_\_\_

**Secondary:** Insurance Company Name / Phone:

\_\_\_\_\_  
\_\_\_\_\_

Insured Employer: \_\_\_\_\_

Insured Soc Sec #: \_\_\_\_\_

Group Number: \_\_\_\_\_

As a service to you, we will complete and file your insurance claim forms for completed treatment. Please remember that insurance plans are usually not designed to pay for everything. We urge you to read your policy. We will do our utmost to see that you receive maximum benefits within the structure of your insurance plan. Your portion of payment (the costs your insurance will not cover) is due at the time of service. Accepted forms of payment include: Cash/Check, Visa or MasterCard, or online by PayPal.

If you have no insurance, payment for service is due at the time of treatment. To assist you we offer the following options for payment: Cash/Check, Visa or MasterCard, or online by PayPal.

### ***Financial Policy***

We understand and appreciate your concerns regarding fees associated with treatment, and feel that you should have a clear understanding of your financial commitment for services provided. We will be happy to discuss fees anytime prior to treatment. As our patient, you should fully understand our mutual obligations and responsibilities.

In consideration of the required professional services provided to the above patient, I/we agree to pay the account for these services in full, at the time of service, unless prior arrangements have been made with Dr. Minnoch/Office Manager. A finance charge of 1.0% monthly will be added to my outstanding account balance after 30 days and 18% on balances over 120 days old.

By signing my name, I agree to this patient registration contract and acknowledge the financial policy. I also attest that all patient, spouse, health and dental information provided are accurate.

I authorize payment directly to Dr. Minnoch for all insurance benefits. I authorize the above doctor and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

### ***Cancellation Policy***

When you make an appointment, we reserve time exclusively for you. **48 hours** notice is appreciated if you are unable to keep your appointment. We reserve the right to **charge for appointments cancelled or broken.**

Signature of Responsible Party \_\_\_\_\_ Date \_\_\_\_\_