

Heritage Dental

(Please Print)

Home Phone: _____

Cell Phone: _____

Name: _____ SSN: _____

Address: _____ City: _____ State: _____ Zip: _____

Sex: M _____ F _____ Age: _____ Birthdate: _____ - _____ - _____

Marital Status:

Single _____ Married _____ Divorced _____ Widowed _____ Separated _____

Employer: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Spouse Name: _____ Birthdate: _____

Employer: _____ Workphone: _____

Occupation: _____ Bus. Address: _____

Who is responsible for payment: _____ Relation: _____

Do you have Dental Insurance: Yes / No Name of Company: _____

Name of Insured: _____ DOB: _____ SSN#: _____ - _____ - _____

Group # _____ Insurance phone #: _____

Do you have Secondary Insurance: Yes / No Name of Company: _____

Name of Insured: _____ SSN#: _____ - _____ - _____

Group #: _____ Insurance Phone# _____

In case of emergency, please notify:

Name: _____ Phone: _____

Whom may we thank for you referring you? _____

Reason for your visit today? _____

E-Mail Address: _____

Medical History Form

Name: _____ Email: _____

Street Address: _____ City: _____ St: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone : _____

For the following questions, circle yes or no, whichever applies. Your answers are for our records only and will be considered confidential.

Are you in good health ?	Yes	No
Has there been any change in your health in the past year?	Yes	No
Are you now under the care of a physician?	Yes	No
If yes, for what condition? _____		
My last physical exam was on?	____/____/____	
The name and address of my physician is: _____		

Have you had any serious illness, operation or hospitalization within the past 5 years?	Yes	No
Are you taking any medication(s) including non-prescription, vitamins, homeopathic or "natural" remedies including diet pills?	Yes	No
Is so, please list (additional space on next page) _____		

Do you have or have had any of the following diseases or problems?

- | | | |
|-------------------------------------------------------------------------------------|-----|----|
| a. Damaged heart valves, artificial valves or heart murmur | Yes | No |
| b. Rheumatic Heart Disease | Yes | No |
| c. Heart trouble, heart attack, angina, high blood pressure, stroke | Yes | No |
| d. Arteriosclerosis or any other heart condition | Yes | No |
| e. Chest pain upon exertion | Yes | No |
| f. Shortness of breath after mild exercise | Yes | No |
| g. Do your ankles swell? | Yes | No |
| h. General allergies | Yes | No |
| i. Sinus trouble | Yes | No |
| j. Asthma or hay fever | Yes | No |
| k. Fainting spells or seizures | Yes | No |
| l. Diabetes | Yes | No |
| m. Hepatitis, jaundice or liver disease | Yes | No |
| n. Frequent or recurring mouth sores | Yes | No |
| o. Thyroid problems | Yes | No |
| p. Respiratory problems, emphysema, bronchitis, etc | Yes | No |
| q. Arthritis or painful, swollen joints including jaw joint (TMJ) | Yes | No |
| r. Stomach ulcer or hyperacidity | Yes | No |
| s. Kidney trouble | Yes | No |
| t. Tuberculosis | Yes | No |
| u. Persistent cough or cough that produces blood | Yes | No |
| v. Persistent swollen neck glands | Yes | No |
| w. Low blood pressure | Yes | No |
| x. Epilepsy or neurological disorder | Yes | No |
| y. Cancer | Yes | No |
| z. Any disease, drug or transplant operation that has depressed your immune system? | Yes | No |

Are you or have you ever been on medication for osteoporosis? How long _____?	Yes	No
Have you had abnormal bleeding?	Yes	No
Have you ever required a blood transfusion?	Yes	No
Do you have any blood disorder such as anemia?	Yes	No
Have you ever had treatment for a tumor or growth?	Yes	No
Are you allergic to or have had a reaction to any of the following?:		
a. Local anesthetics	Yes	No
b. Penicillin	Yes	No
c. Other antibiotics	Yes	No
d. Sulfa drugs	Yes	No
e. Barbiturates or sleeping pills	Yes	No
f. Aspirin	Yes	No
g. Iodine	Yes	No
h. Codeine	Yes	No
i. Other narcotics or other medications	Yes	No
Have you had any serious trouble associated with previous dental treatment?	Yes	No
Do you smoke? How much _____?	Yes	No
Do you consume alcohol regularly? Is yes, how much daily _____?	Yes	No
Do you have any other conditions or diseases you think the doctor should know?	Yes	No
If yes, please explain _____		
Are you wearing contact lenses?	Yes	No
Are you wearing removable dental appliances? How old are they _____?	Yes	No

WOMEN

Are you pregnant or trying to become pregnant?	Yes	No
Do you have problems associated with your menstrual period?	Yes	No
Are you nursing?	Yes	No
Are you taking birth control pills?	Yes	No

Chief Dental Complaint: _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth have been answered to my satisfaction. I will not hold my dentist, or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form.

Date: _____ **Patient Signature:** _____

FOR COMPLETION BY THE DOCTOR

Comments on patient interview concerning medical history: _____

Significant finding from questionnaire or oral interview: _____

Dental management considerations: _____

Date: _____ Doctor's Signature _____

PLEASE LIST ANY ADDITIONAL MEDICATIONS THAT YOU ARE TAKING:

Dental History

Do you like your smile? Yes / No

What would you change about your smile? _____

Are you in pain? Yes / No Date of last cleaning? _____

What did you dislike most about your last dental visit? _____

Do you smoke? Yes / No Do your gums bleed? Yes / No

Any discomfort in your jaw joint (TMJ/TMD)? Yes / No

Have you ever had any periodontal (gum) treatment? Yes / No
If yes, when? _____

PRE-MEDICATION MEDS: _____

Agreement of Payment

Patients with our without insurance need to sign

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I authorize payment of my insurance benefits directly to Heritage Dental. I understand that **I am fully responsible for all cost of my dental treatment** and will be informed of the fee and understand that **(regardless of insurance coverage, I may or may not have)**. Should insurance payment be denied or reimbursement less than approximated amount, for any reason, I am responsible for the total treatment fee, responsibility and all fees not paid by my insurance after 60 days are my full responsibility.

Date: _____

Signature: _____