Patient Medical History

Patient's Name _____ **Date of Birth** _____

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 that you will be receiving. Thank you for answering the following questions.

	YES	NO
1. Are you in good health _____	☐	☐
2. Have there been any changes in your general health within the past year _____	☐	☐
3. **PHYSICIAN's name** _____		
4. Are you now under the care of a physician _____	☐	☐
5. Have you ever been hospitalized for any surgical operation or serious illness _____	☐	☐
Please explain _____		
6. Are you taking any medicine(s), including non-prescription medicine and supplements? _____	☐	☐
If yes, **PLEASE LIST MEDICATIONS HERE** _____		
_____		
_____		
_____		
_____		

	YES	NO
7. Have you had any abnormal bleeding _____	☐	☐
8. Do you bruise easily _____	☐	☐
9. Have you ever required a blood transfusion _____	☐	☐
10. Have you had a recent weight loss _____	☐	☐
11. Have you ever taken Fen-Phen or Redux _____	☐	☐
12. Do you use tobacco _____	☐	☐
13. Do you or have you used controlled substances _____	☐	☐
14. Do you have any disease, condition, or problem not listed above that you think I should know about: _____	☐	☐
_____		
Women only:		
Are you pregnant or think you may be pregnant _____	☐	☐
Are you nursing _____	☐	☐
Are you taking birth control pills _____	☐	☐

Are you **ALLERGIC** to or have you had reactions to:	YES	NO
Local anesthetics like novocaine _____	☐	☐
Penicillin or other antibiotics _____	☐	☐
Sulfa drugs _____	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐
Aspirin _____	☐	☐
Iodine _____	☐	☐
Any metals (e.g., nickel, mercury, etc.) _____	☐	☐
Latex/rubber _____	☐	☐
Other (please list) _____		
Do you have, or have you ever had, any of the following:		
Rheumatic heart disease or rheumatic fever _____	☐	☐
Scarlet fever _____	☐	☐
Heart defect or heart murmur _____	☐	☐
Heart trouble, heart attack, or angina _____	☐	☐
Chest pain _____	☐	☐
Hives or skin rash _____	☐	☐
Pacemaker _____	☐	☐
Heart surgery _____	☐	☐
High/low blood pressure _____	☐	☐
Congenital heart problem _____	☐	☐
Swelling of feet, ankles, hands _____	☐	☐
Hepatitis, jaundice, or liver disease _____	☐	☐
Stroke _____	☐	☐
Sinus trouble _____	☐	☐
Lung or breathing problems _____	☐	☐
Asthma or hay fever _____	☐	☐

	YES	NO
Fainting or dizzy spells _____	☐	☐
Diabetes _____	☐	☐
AIDS or HIV infection _____	☐	☐
Thyroid problem _____	☐	☐
Seasonal Allergies _____	☐	☐
Arthritis or rheumatism _____	☐	☐
Joint replacement – requires premedication? _____	☐	☐
Stomach ulcer _____	☐	☐
Kidney trouble _____	☐	☐
Tuberculosis _____	☐	☐
Persistent cough _____	☐	☐
Cancer _____	☐	☐
Chemotherapy _____	☐	☐
Sexually transmitted disease _____	☐	☐
Epilepsy or seizures _____	☐	☐
Anemia _____	☐	☐
Glaucoma _____	☐	☐
Nervousness _____	☐	☐
Tonsillitis _____	☐	☐
Tumors _____	☐	☐
Mental health care _____	☐	☐
Back problems _____	☐	☐
Chemical dependency _____	☐	☐
Mitral valve prolapse – requires premedication? _____	☐	☐
Eating disorders _____	☐	☐
Cold sores/fever blisters _____	☐	☐
Hypoglycemia _____	☐	☐

Signature of patient or parent/guardian of minor X _____ Date: _____

ZIEBA & FAMILY DENTISTRY

Patient Information

Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Cell # _____ Soc. security # _____ Birth date _____ Home phone _____

Email _____

Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's or parent's employer _____ Work phone _____

Whom may we thank for referring you _____

Person to contact in case of an emergency _____ Phone _____

Responsible Party

Name of person responsible for this account _____ Relationship to patient _____

Address _____ Home Phone _____

Birth date _____ Soc. security # _____

Employer _____ Work phone _____

Is this person currently a patient in our office ☐ Yes ☐ No

Insurance Information

Name of insured _____ Relationship to patient _____

Birth date _____ Soc. security # _____ Date employed _____

Name of employer _____ Union or local # _____ Work phone _____

Insurance co. _____ Tel. # _____ Grp. # _____ Policy/I.D. # _____

Do you have a secondary dental insurance? ☐ Yes ☐ No If yes, complete the following:

Name of insured _____ Relationship to patient _____

Birth date _____ Soc. security # _____ Date employed _____

Name of employer _____ Union or local # _____ Work phone _____

Insurance co. _____ Tel. # _____ Grp. # _____ Policy/I.D. # _____

Signature of patient or parent/guardian of minor X _____ Date: _____

Patient Dental History

Patient's Name _____ **Date of Birth** _____

Reason for this visit _____

When was your last dental visit _____ What was done then _____

How often did you visit the dentist before then _____

Previous dentist (name and location) _____

Have you had a complete series of dental exams (x-rays) taken? When and where _____

How often do you brush your teeth _____ How often do you floss your teeth _____

Is your drinking water fluoridated _____

	YES	NO
Do your gums bleed while brushing or flossing	☐	☐
Are your teeth sensitive to hot or cold liquids/foods	☐	☐
Are your teeth sensitive to sweet or sour liquids/foods	☐	☐
Do you feel pain to any of your teeth	☐	☐
Do you have any sores or lumps in or near your mouth	☐	☐
Have you had any head, neck, or jaw injuries	☐	☐
Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐
Do you have frequent headaches	☐	☐
Do you clench or grind your teeth	☐	☐
Do you bite your lips or cheeks frequently	☐	☐

	YES	NO
Have you noticed any loosening of your teeth	☐	☐
Does food tend to become caught between your teeth	☐	☐
Have you ever had periodontal treatment (gums)	☐	☐
Ever worn a bite plate or other appliance	☐	☐
Have you ever had any difficult extractions in the past	☐	☐
Have you ever had any prolonged bleeding following extractions	☐	☐
Do you wear dentures or partials	☐	☐
If yes, date of placement		
Have you ever received oral hygiene instructions regarding the care of your teeth and gums	☐	☐
Have you had ortho/braces in the past	☐	☐
Would you be interested in teeth whitening	☐	☐
Have you had an unfavorable dental experience	☐	☐

If you could change anything about your smile what would you change? _____

_____

_____

Appointments: We reserve the right to charge $45 per hour for repeated no shows or cancellations without 48 hours advance notification. Once an appointment is made, please remember this time is reserved for you.

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release my information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of patient or parent/guardian of minor X _____ Date: _____