McMinnville Family Dental

Patient Information **Today's Date:** _____

Patient Name _____ Referred by _____

Address _____ City _____ State _____ Zip _____

Birth Date _____ Home Phone _____ Mobile Phone _____

Person to notify in case of emergency _____Phone _____

Social Security Number _____ Physician's Name _____ City_____

Billing Information

Responsible Party _____ Phone _____

Address _____ City _____ State _____ Zip _____

Insurance Information

1 – Name of Insured _____ Subscriber Birth Date _____

Employer _____

Insurance Company _____ Group # _____ Subscriber ID _____

2 – Name of Insured _____ Subscriber Birth Date _____

Employer _____

Insurance Company _____ Group # _____ Subscriber ID _____

Medical/Dental Information

These answers are vital in helping us to provide you with the best treatment possible and also to avoid any cross reactions of drugs or health conditions.

Please circle

1. Do you have a specific dental problem? ☐ Yes ☐ No
2. Do you have any sores or growths in your mouth? ☐ Yes ☐ No
3. Date of last full mouth x-rays (18 small films or panoramic film): _____
4. Have you had your third molars (wisdom teeth) removed? ☐ Yes ☐ No
5. Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No

Discuss

_____

_____

Female

6. Are you pregnant? ☐ Yes ☐ No

Due Date _____

7. Are you nursing? ☐ Yes ☐ No
8. Are you taking birth control pills? ☐ Yes ☐ No

9. Please list all medications, over the counter drugs, vitamins/herbs, aspirin, etc., that you are taking.

_____

_____

10. Please list all allergies including medications, latex, substances, metals, pollen, and food.

_____

11. Please advise us of any drugs you are using – IV, street/recreation drugs, etc. – as they may have an adverse reaction with your dental treatment.

_____

(over)

12. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
Congestive Heart Failure	☐	☐	Asthma	☐	☐	Psychiatric Treatment	☐	☐
Heart Attack	☐	☐	Sinus Trouble	☐	☐	Depression	☐	☐
High Blood Pressure	☐	☐	Allergies or Hives	☐	☐	Anxiety Disorder	☐	☐
Congenital Heart disorder	☐	☐	Emphysema	☐	☐	Eating Disorder	☐	☐
Artificial Heart Valves	☐	☐	Chronic Cough	☐	☐	Tumor or Cancer	☐	☐
Pacemaker or Defibrillator	☐	☐	Tuberculosis (TB)	☐	☐	Remission since _____	☐	☐
Stent	☐	☐	Breathing Difficulties	☐	☐	Radiation Treatment	☐	☐
Arrhythmias	☐	☐	Diabetes	☐	☐	Chemotherapy	☐	☐
Aneurysm	☐	☐	Kidney Trouble or Dialysis	☐	☐	Bisphosphonate Medication	☐	☐
Angina/Chest Pain	☐	☐	Excessive Thirst	☐	☐	Use Tobacco	☐	☐
Heart Surgery	☐	☐	Thyroid Disease	☐	☐	Use Alcohol	☐	☐
Other Heart Problems	☐	☐	Arthritis/ Rheumatism	☐	☐			
Stroke	☐	☐	Fibromyalgia	☐	☐			
Anemia	☐	☐	Artificial Joints	☐	☐	Other _____		
Hemophilia	☐	☐	Other Bone Problems	☐	☐	_____		
Taking blood thinner	☐	☐	Systemic Lupus	☐	☐	_____		
Bleed longer than normal	☐	☐	Cortisone or Steroid Med	☐	☐	_____		
Leukemia	☐	☐	Liver Disease	☐	☐			
HIV/AIDS	☐	☐	Hepatitis	☐	☐			
Gastric Acid Reflux	☐	☐	Drug or Alcohol Addiction	☐	☐			
Stomach/Intestinal Disease	☐	☐	Epilepsy or Seizures	☐	☐			
Glaucoma	☐	☐	Fainting or Dizzy Spells	☐	☐			

I certify that the above history is correct to the best of my knowledge. I consent to routine dental procedures as needed including x-rays, cleanings, local anesthesia, and dental restorations. I understand that complications of dental care may include bruising, hematoma, cardiac stimulation, muscle soreness and temporary, or rarely permanent, numbness.

Signature _____ Date _____

---------- *(Office use only)* ----------

Date reviewed & initials _____ Date reviewed & initials _____ Date reviewed & initials _____

Date reviewed & initials _____ Date reviewed & initials _____ Date reviewed & initials _____

Date reviewed & initials _____ Date reviewed & initials _____ Date reviewed & initials _____