NEW PATIENT MEDICAL HISTORY

Patient's Name:_____

Dr. Kenneth G. French Dr. Kevin Bougher Dr. Allen Hovan Dr. Michelle Sayour

The following information is necessary in order that the dentist may thoroughly diagnose any condition and give you personal attention. You must be accurate for your health's sake. This information is confidential.

MEDICAL HISTORY

1. Date of your last medical check up_____

2. How do you estimate your general health: ( ) Good ( ) Fair ( ) Poor

3. Circle any of the following which you have had or have at present:

Heart Attack/Disease	Rheumatic Fever	Chronic Bronchitis	Glaucoma	Epilepsy or Seizures
Congenital Heart Lesions	Scarlet Fever	Tuberculosis	HIV+/AIDS	Growth/Tumor
Angina Pectoris	Artificial Joint	Asthma	Hepatitis A (infectious)	Mental/Nervous ds
Heart Surgery	Anemia	Diabetes	Hepatitis B (serum)	Fainting/Dizzy Spells
Heart Pacemaker	Stroke	Thyroid Disease	Liver Disease	Bruise Easily
Artificial Heart Valve	Kidney Disease	Radiation Therapy	Blood Transfusion	Gastrointestinal ds
Mitral Valve Prolapse	Ulcers	Chemotherapy	Drug/Alcohol Abuse	Malignant Hyperthermia
High Blood Pressure	Emphysema	Cortisone Therapy	Hemophilia	Other_____

4. Do you get chest pains upon exertion or shortness of breath after mild exercise? Yes No

5. Do you get swelling of your ankles or have difficulty lying flat on your back? Yes No

6. Have you ever experienced allergic reaction (itching, rash, swelling or wheezing) to codeine, aspirin, penicillin, local anaesthetic (dental freezing) or other_____? Yes No

7. Have you ever had any excessive bleeding requiring treatment? Yes No

8. Are you currently taking any medication? If yes, please list and include over the counter medications and herbal remedies _____ Yes No

_____

_____

9. Do you smoke? If so, how much?_____ Yes No

10. WOMEN: Are you pregnant? Expected delivery date_____ Yes No

Are you using birth control pills? Yes No

DENTAL HISTORY

1. What concerns you most about your dental health? _____

2. Do you feel nervous about having dental work done? Yes No

3. Did you have a bad dental experience in the past? If so, what? _____ Yes No

4. Date of your last dental check up_____Dentist _____

5. Do your gums bleed or hurt? Yes No

6. Do you clench or grind your teeth? Yes No

7. Would you like to improve your smile? Yes No

8. If you are unhappy with your smile, what would you like to change about it? _____

_____

_____

9. How often do you brush?_____ Floss?_____ Other?_____

10. Do you use an electric/battery operated toothbrush? Yes No Type? _____

To the best of my knowledge, all of the preceding information is accurate and I will advise this office of any future changes. I authorize the doctor and/or his staff to perform diagnostic and treatment procedures as required for proper dental care. I also authorize the release of personal information for the purpose of evaluation and claiming insurance or other benefits and also to other health care providers for consultation or treatment. I understand I am financially responsible for fees associated with the procedures.

PATIENT SIGNATURE_____**DATE**_____

(If patient is under 18, guardian signature)

INSURANCE INFORMATION

Company: _____
Plan A: _____%
_____Limit
Plan B: _____%
_____Limit
Plan C: _____%
_____Limit
R/C Interval = _____Months
Comps on Molars? _____

Company: _____
Plan A: _____%
_____Limit
Plan B: _____%
_____Limit
Plan C: _____%
_____Limit
R/C Interval = _____Months
Comps on Molars? _____

OTHER INFORMATION

MEDICAL HISTORY UPDATES