Patient's Name ________________________________ Date ______________

LAST FIRST MIDDLE

We are concerned about your dental and medical health. The following is requested to thoroughly diagnose any condition and to render the highest possible standards of professional service. Please explain any positive responses.

How do you feel about your teeth? ______________________________

Is there anything you would like to change about your teeth or smile? ______________________________

____

In the past, have you visited your dentist on a regular basis or just when you had a problem? ______________

When did you last visit a dentist? ____________ What for? ______________________________

What type of x-rays were taken? Single film _____ Bitewing _____ Full series _____ Panoramic ________

A copy of your previous dental records including x-rays within the past 5 years is always beneficial. We ask that you request a copy sent to us prior to your examination appointment.

Do your gums bleed when you brush or floss? ______________________________

Do you have any unpleasant odor or taste in your mouth? ______________________________

Were periodontal pockets recorded last time at the dentist? ______________________________

Have you experienced any swelling, lumps, or sore spots in your mouth? ______________________________

Have you had any extractions? ________ Any Problems? ______________________________

Have any missing teeth been replaced? ______________________________

Have you ever had orthodontic (braces, retainer), periodontic (pyrrehea, gum disease), or gum treatment? ________

Have you ever sustained any trauma to teeth, jaw structures, or concussion? ______________________________

Do you wear a mouth guard if you participate in contact sports? ______________________________

Do you clinch or grind your teeth during day or night? ______________________________

Does your jaw click or pop? ______________________________

Do you have any pain in jaw joint or face – in or about your ears? ______________________________

Do you experience chronic headaches? ______________________________

Are you aware of any particular dental problems? ______________________________

Does food catch between your teeth? ______________________________

Are any teeth sensitive to hot, cold, sweet or pressure? ______________________________

Has fear or discomfort kept you from regular visits? ______________________________

Have you ever had a problem with dental anesthetics (numbing)? ______________________________

Have you ever used or prefer nitrous oxide (laughing gas)? ______________________________

How important is it to eliminate future dental problems? ______________________________

Are you interested in regular preventive care or just emergency service? ______________________________

Have you ever had any problems or complications with previous dental treatment? ______________________________

If yes, please explain ______________________________

Is there anything about previous dental treatments you particularly enjoyed or made your visits easier? (please explain)

____

Do you have any questions or concerns? (please explain) ______________________________

____

Dental Summary (by staff) ______________________________

____

Staff reviewers initials ________ Date ____________

ANESTHETIC	ADULT DENTAL HISTORY	MED ALERT

PATIENT'S NAME ______________________________ DATE ______________
LAST FIRST MIDDLE

We are concerned about your dental and medical health. The following information is requested to thoroughly diagnose any condition and to render the highest possible standards of professional service. All information will be kept strictly confidential.

PHYSICIAN ______________ PHONE NO. ________ LAST MEDICAL EXAM DATE ________

Do you have or have you had any of the following? Space is provided for further explanations.

- ☐ Any heart problems
- ☐ High blood pressure
- ☐ Rheumatic fever
- ☐ Heart murmur
- ☐ Heart implant/pacemaker
- ☐ Circulatory problems
- ☐ Stroke
- ☐ Excessive bleeding
- ☐ Blood disease
- ☐ Anemia
- ☐ History of fainting
- ☐ Nervous problems
- ☐ Ulcer
- ☐ Psychiatric care
- ☐ Epilepsy
- ☐ Radiation treatments
- ☐ Tumors or growths
- ☐ Cancer
- ☐ Arthritis
- ☐ Asthma
- ☐ Shortness of breath
- ☐ Stomach problems
- ☐ Skin disease
- ☐ Excessive weight gain or loss
- ☐ Operation: Date ____________
  Type ______________
- ☐ Allergies to anesthetics
- ☐ Allergies to medicines, drugs or foods
- ☐ Allergic to: ______________
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Drug/alcohol addiction
- ☐ Head injuries
- ☐ Hepatitis, liver problems
- ☐ Kidney disease
- ☐ Sinus problems
- ☐ Glaucoma
- ☐ Tuberculosis
- ☐ Venereal disease
- ☐ Cold sores
- ☐ A.I.D.S./H.I.V. Pos.
- ☐ Artificial joint
- ☐ Latex allergy

Further explanation ____

____

Are you under a physician's care? ________ For what reason? ______________________

Are you allergic to or have you had any adverse reaction to any medications? ______________________

Are you taking medication now or in the past six months? If so, name of medication and reason for taking. ____________

____

____

Please describe any current medical treatments, impending surgery or any other medical information. ____________

____

Women only: Are you taking birth control pills? ______________________

Are you pregnant or suspect you may be? ________ How many months? ________ Due Date ________

DOCTOR'S MEDICAL SUMMARY:

Blood Pressure S________/D________ Pulse ________

____

____

Consult Need ☐ Yes ☐ No Staff reviewer's initials ________ Date ______________

MEDICAL UPDATE:

____

____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor at the next appointment without fail.

X ______________________________ ______________

PATIENT SIGNATURE/PERSON COMPLETING FORM, IF NOT PATIENT **DATE**

ANESTHETIC

ADULT MEDICAL HISTORY

MED ALERT

PATIENT INFORMATION

Date ______________________

Patient's Name ____
Last First Middle

How would you like to be addressed (nickname) ______________________________ Male ☐ Female ☐

Address ________________________________ City ______________ State _____ Zip Code __________

Telephone (Home) ________________________ (Work) _____________________ Ext. _______________

Social Security Number ___________________________ Age ____________ Birthdate _______________

Occupation _________________________________ Employed by _________________________________

Married ☐ Single ☐ Minor ☐ Spouse's Name _______________________ Number of Dependents ____

Other family members treated in our office ____

Name of family member living nearest to you _____________________________ (phone) _________________

REFERRAL INFORMATION

Whom may we thank for referring you to our office?

☐ Another patient, friend ☐ Another patient, relative ☐ Dental office ☐ Yellow pages ☐ Work ☐ School ☐ Other

Name of person or office referring you to our practice ____________________________________

RESPONSIBLE PARTY

If patient is not financially responsible for professional services, please indicate who is responsible.

Name ____ Relationship __________________________

Address ____

City ______________________________________ State _______________ Zip Code _______________

Social Security Number _________________________ Telephone _______________________________

I acknowledge responsibility for payment of dental services rendered to above named patient, including any amount not paid by insurance company (if any). If for any reason the account should become delinquent, I agree to pay for all collection and legal fees.

Signature of responsible party ____

INSURANCE INFORMATION

	Primary Carrier	Secondary Carrier
Subscribers (employee) name	________________________	________________________
Relationship to patient	________________________	________________________
Birthdate / Social Security No.	__________ / _____________	__________ / _____________
Employer	________________________	________________________
Insurance Company	________________________	________________________
Group or Policy Number	________________________	________________________

I authorize release of any information regarding dental treatment of above named patient and payment directly to Fishers Family Dentistry of the insurance benefits otherwise payable to me.

Signature of Insured Person ____________________________________ Date _______________

For office services, we ask that you pay as you go. We will be happy to file a claim with your insurance company for your reimbursement. When we do extend your credit, you will receive a statement each month. We file insurance claims promptly and any payments from your insurance company are usually received within 30 to 45 days. When any part of your balance becomes 60 days old, a service charge of 1.5% per month (18% per year) may be added.

STAFF NOTES ____

____

____

ADULT REGISTRATION

MED ALERT