ARUNDEL DENTAL GROUP

Date _____

Patient Name (Mr. Mrs. Miss) _____

If a child, parent's name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Business Phone _____

Cell Phone _____

Date of Birth _____ Age _____ Sex Male Female

Social Security Number _____

Marital Status _____

Who referred you to our office? _____

_____

In case of emergency, contact: _____

Phone _____

Are you covered by any dental insurance? _____

If so, which plan? _____

Name of insured? _____ Date of Birth _____

Employer _____

Social Security # of insured _____
(if is not your own plan)

Any secondary coverage information _____

_____

Signature _____
(to be used as signature on file for insurance purposes, if necessary)

PATIENT MEDICAL HISTORY

Approximate date of last physical exam _____

Are you under any medical treatment now? Yes No

If so, what? _____

Do you currently have, or have you had:

Heart disease?	Yes	No
Heart attack or stroke?	Yes	No
Rheumatic fever?	Yes	No
Heart murmur?	Yes	No
Mitral valve prolapse?	Yes	No
Prosthetic joints?	Yes	No
Diabetes or high blood sugar?	Yes	No
Epilepsy or seizures?	Yes	No
Respiratory disease?	Yes	No
Kidney disease?	Yes	No
Liver disease or blood disorder?	Yes	No
High blood pressure?	Yes	No
Fainting spells?	Yes	No
Prolonged bleeding?	Yes	No
Hepatitis or yellow jaundice?	Yes	No
Asthma or hay fever?	Yes	No
Anemia?	Yes	No
Sinus problems?	Yes	No
Any veneral disease?	Yes	No
HIV or AIDS?	Yes	No
Are you being treated for alcoholism or are you in a drug rehabilitation program?	Yes	No
Do you smoke cigarettes?	Yes	No
Are you pregnant?	Yes	No
Are you taking any drugs or medications?	Yes	No
Are you on birth control pills?	Yes	No
Are you allergic to penicillin?	Yes	No
codeine?	Yes	No
latex?	Yes	No
other meds?	Yes	No
Have you ever been advised to pre-medicate before dental treatment?	Yes	No

Your medical doctor: _____

Phone number, *if known* _____

PATIENT DENTAL HISTORY

Do you have a specific problem? _____

Have you had any problems with past dental treatment?	Yes	No
Do you have a frequent dry mouth?	Yes	No
Have you had any difficult extractions in the past?	Yes	No
Do you have any problems with local anesthetic?	Yes	No
Do you have any fear of dental treatment?	Yes	No
Do your gums bleed?	Yes	No
Have you ever been told you have periodontal or gum disease?	Yes	No
Are any of your teeth sensitive to hot or cold?	Yes	No
Do you avoid chewing on any teeth due to biting discomfort?	Yes	No
Have you had any injuries to the face or jaws?	Yes	No
How many times daily do you brush?	_____	
Do you floss on a daily basis?	Yes	No
Are you happy with the appearance of your smile?	Yes	No
Anything else you feel is important?	Yes	No

_____

_____

_____

Updated on _____ by _____

Updated on _____ by _____

Updated on _____ by _____

Updated on _____ by _____

Updated on _____ by _____

Updated on _____ by _____

HEALTH HISTORY UPDATES

Date	Initials/Signature	Changes in health or medication Any other pertinent health info: